TITLE: Workers' Compensation Claims Reporting

NUMBER: Ref-1279.1

ISSUER: Enrique G. Boull't, Chief Operating Officer
Office of the Chief Operating Officer

DATE: November 11, 2013

ROUTING

All Employees

All Locations

PURPOSE: The purpose of this Reference Guide is to provide guidance and procedures when an employee reports a work related injury/illness.

MAJOR CHANGES: This Reference Guide replaces REF-1279, dated September 3, 2004. The content has been revised to reflect changes to procedures, contacts and forms.

INSTRUCTIONS: All required forms can be found in the attachments or at http://disabilitymanagement.lausd.net

OVERVIEW:

Workers' Compensation is a state-mandated benefit for employees with work related injuries/illnesses. The Los Angeles Unified School District is self-insured for these benefits. Self-insurance means that the District, not an insurance company, pays the costs of the workers' compensation claims. The District has contracted with Sedgwick, a third party administrator (TPA), for management of workers' compensation claims.

Workers' compensation benefits include medical treatment, temporary disability benefits (percentage of salary) if the employee is unable to work during recovery, and permanent disability benefits if the injury results in permanent impairment.

The California Education Code provides eligible employees up to 60 days of continued salary in lieu of temporary disability benefits. If an employee remains temporarily disabled after 60 days of salary continuation, then the employee will receive the temporary disability benefits, supplemented by their accrued illness/vacation pay.

The District has a state-approved Medical Provider Network (MPN). This is a network of physicians that provide medical care for workers' compensation injuries/illnesses. In most cases, an injured employee must receive medical

care from a physician within the MPN.

ADMINISTRATOR/DESIGNEE RESPONSIBILITIES:

1. **Assist the employee in obtaining medical care.**
   Emergency medical situations: If emergency medical care is required, immediately call 911.

   Non-emergency medical situations:

   a) The District has a state-approved Medical Provider Network (MPN). All non-emergency medical care must be obtained from a provider in the MPN. An exception is allowable if the employee pre-designated their personal physician prior to the injury (see section on predesignation).

   b) The MPN Referral Panel is a partial list of first-care providers within the District's geographical area. In order to expedite treatment, any medical provider from this list can be recommended to the injured employee.

      The referral panel is available at
      http://disabilitymanagement.lausd.net

      The full MPN list can be accessed as follows:
      Go to www.coventrywcs.com
      Select Client Log In and Tools
      Select FOCUS/Coventry Login (GeoAccess Channeling Tools)
      Enter client ID "Sedgwickkaisercampn"

   c) Print and sign a *Medical Authorization* form (Attachment A) and give the signed form to the employee. By signing this form, you are only authorizing the first visit. Subsequent medical care must be authorized by Sedgwick, the TPA.

   d) Print and sign the *Temporary Pharmacy Card* (Attachment B) and provide the card to the employee. The temporary pharmacy card, when presented to a participating pharmacy with a valid prescription, will allow the employee to receive the first fill of medication prescribed for a work related injury/illness. Sedgwick will mail to the employee a pharmacy card for subsequent prescriptions.

2. **Provide the employee with the *Workers' Compensation Claim Form (State of California, DWC1)***
   Providing the *claim form* (Attachment C) to the employee within 24 hours' notice of a work related injury/illness is a state requirement.
   a) The employee must complete the top section of the form and return the form to the work location
   b) The work location then must:
      1. Complete the lower section of the claim form
      2. Forward the original form to Sedgwick, at
         P.O. Box 14623
         Lexington, KY 40512-4623
      3. Provide a copy to the injured employee
      4. Retain a copy of the form

   If the employee is not available when notice of injury/illness is received, the claim form should be mailed to the employee's address of record within 24 hours and a copy kept in the employee's personnel file with the date mailed. The claim form does not have to be mailed certified mail or return receipt.

3. **Investigate the injury.**
   Investigate the injury, as soon as possible and complete the Injury/ Incident Investigation Report. The Injury/Incident Investigation Report is part of the ISTAR reporting system.

4. **Report the Injury/Illness to the District's TPA**
   It is not necessary to report incidents only requiring first aid.

   If the injury/illness results in lost time from work and/or medical treatment, the injury must be reported to Sedgwick. It is important that injuries/illnesses are reported promptly in order to comply with state requirements.

   a) The *Workers' Compensation Injury Report Worksheet* (Attachment D) lists the information required when reporting a claim to Sedgwick. Completion of the worksheet prior to calling in the claim is not mandatory, but is recommended to ensure that the required information is available when the claim is reported.
   b) Call the Sedgwick National Intake Center at (800) 528-7392 (toll free). Your call will be answered by a live operator who will request the information on the *Injury Report Worksheet.* At the conclusion of the call, the Intake Operator will provide a claim number for the injury. The claim number should be recorded on the worksheet for future reference.

EMPLOYEE RESPONSIBILITIES:

1. Immediately report all work related injuries/illnesses to a supervisor/manager.
2. Comply with all District absence policies such as submitting Requests for Leave of Absence if absence extends beyond 20 days and notifying the work location of an absence.
3. Complete *Salary Continuation Benefit Verification Form* (Attachment E), if applicable.
    a) Temporary disability benefits are not paid for the first three days of lost time or for partial days off due to doctor's appointments. The District will, however, pay this time as workers' compensation for up to 60 days as provided in the Education Code if the *Salary Continuation Benefit Verification Form* is received by Payroll Services. This form is available on the Workers' Compensation Department's website and is also sent to the injured employee by Sedgwick with their initial packet.
    b) The *Salary Continuation Benefit Verification Form* must be signed by the employee and the physician or therapist and then sent to Sedgwick at P.O. Box 14623, Lexington, KY 40512. The Sedgwick claims adjuster will authorize the time off if appropriate by signing the form and forwarding it to the Payroll Department. A copy of the form should also be provided to the worksite.

PREDESIGNATION:

Prior to an injury, an employee may pre-designate a personal physician to provide treatment for industrial injuries. An employee will be allowed to receive medical treatment outside of the District's MPN if a completed form is on file prior to an injury.

The completed *Pre-designation of Physician Form* (Attachment F) should be maintained at the work location for reference at the time of injury. In the event of a transfer, the employee must provide a copy of the form to the new work location.

TIME REPORTER RESPONSIBILITES: – Work Related (industrial) injury/illness leave

1. Report the entire day of injury as regular time.
2. When an employee is absent from work because of a work related injury or illness, any time lost after the day the injury occurred should

be reported as "FWC" for workers' compensation if the absence has also been designated as FMLA. The "FWC" code should be used until the employee's FMLA time is exhausted.

3. If the employee is not eligible for FMLA, or has exhausted their FMLA time, report time off as "WC".
   The actual decision as to whether workers' compensation time is paid is made by Sedgwick and communicated by Sedgwick directly to Payroll Services. If the time off is not authorized as temporary disability by Sedgwick, it will be charged against the employee's illness time.
4. Report time off for depositions as regular time.
5. Report time off for court appearances as personal necessity.

STAY AT WORK/RETURN TO WORK:

The Stay at Work/Return to Work program in the Integrated Disability Management Branch is available to assist, if necessary, in identifying and providing modified or alternate duties or other accommodations. The policies and procedures of the Stay at Work/Return to Work program are outlined in the Stay at Work/Return to Work Procedural manual available at http://disabilitymanagement.lausd.net

REASONABLE ACCOMODATIONS:

For information regarding employee accommodations refer to Bulletin 4569.0, *Reasonable Accommodations for Individuals with Disabilities* or contact the Disability Coordinator in the Integrated Disability Management Branch at (213) 241-7630.

ACT OF VIOLENCE:

Members of some bargaining units are entitled to an extension of full pay beyond the 60 days allowed under the Education Code, if the work-related injury was the result of an Act of Violence. Refer to the appropriate bargaining agreement and BUL-5047.1, Act of Violence, for further information.

FRAUD AND ABUSE:

Suspected workers' compensation fraud or abuse should be reported to the LAUSD Office of Inspector General Fraud hotline at (213) 241-7778 or the Sedgwick Special Investigation Unit, toll-free at (866) 247-2287, extension 79271.

POSTING REQUIREMENTS:

All schools and offices must comply with the state requirement to display the current version of the workers' compensation poster entitled "Notice to Employees-Injuries Caused by Work", California Department of Industrial Relations, Division of Workers' Compensation (DWC 7), and rev.6/10. For more information regarding mandatory employment posters, refer to BUL-4991.0, Posting *of Regulatory Notices Relating to State and Federal Laws.*

RELATED RESOURCES:

Act of Violence, BUL-5047.1, issued by the Office of the Chief Operating Officer and the Division of Risk Management and Insurance Services

Family and Medical Leave Act/California Family Rights Act Policy , BUL-1205.1, issued by the Office of the Chief Operating Officer and the Division of Risk Management and Insurance Services

Family and Medical Leave Act/California Family Rights Act – Supervisors' Reference Guide, REF-6022.0 issued by the Office of the Chief Operating Officer and the Division of Risk Management and Insurance Services

Incident System Tracking Accountability Report, BUL-5269.0, issued by School Operations Division

Reasonable Accommodations for Individuals with Disabilities, BUL-4569.0, issued by Office of the Chief Operating Officer and the Office of General Counsel

Posting of Regulatory Notices Relating to State and Federal Employment Laws, BUL-4991.0, issued by the Office of the Chief Operating Officer

Stay at Work Procedural Manual, issued by the Division of Risk Management and Insurance Services at http://disabilitymanagement.lausd.net

Accident Investigation and Reporting, Safety Alert 04-14, issued by the Office of the Chief Operating Officer and Office of Environmental Health and Safety

Injury and Illness Prevention Program Requirements, BUL-3772.2, issued by the Office of Environmental Health and Safety

State of California, Department of Industrial Relations, Division of Workers' Compensation at http://www.dir.ca.gov/dwc/dwc_home_page.htm

ASSISTANCE: Integrated Disability Management, Workers' Compensation Program at 213 241-3138 or visit our website at http://disabilitymanagement.lausd.net. All bulletins, guides and forms can be found on the website.

ATTACHMENTS:

Attachment A – Medical Authorization Form
Attachment B – Temporary Pharmacy Card
Attachment C – Workers' Compensation Claim Form (DWC-1)
Attachment D – Injury Report Worksheet
Attachment E – Salary Continuation Benefits Verification Form
Attachment F – Pre-designation of Physician Form

NOTICE TO INJURED EMPLOYEE TO BE TREATED WITHIN MEDICAL PROVIDER NETWORK (MPN)
&
MEDICAL AUTHORIZATION FORM

To Employee:
After the initial visit to the MPN provider listed below, you are entitled by law to be treated by a physician of your choice within the Sedgwick CMS' Medical Provider Network. This network can be accessed by following these instructions.

1. **Go to www.coventrywcs.com**
2. **Select Client Log In and Tools**
3. **Select the radial button for FOCUS/Coventry Login(GeoAccess Channeling Tools)**
4. **On the client ID screen, key in**
   a. Sedgwickkaisercampn

Your Site Administrator may assist you with access to this website or you may contact Sedgwick CMS at (866) 247-2287 for further assistance.

Injured Worker _____

Work Location _____

Date of Injury _____ **Date of Referral**_____

Site Admin. Name (please print) _____

Site Administrator Signature _____

Site Administrators' Phone Number _____

To Clinic/Physician:
This form when signed by an employer representative authorizes an initial visit by the employee named above to be evaluated and treated by the physician or clinic identified below within the Sedgwick CMS Medical Provider Network. Additional treatment, if necessary, may be provided by the physician or clinic named if selected by the injured worker, or the injured worker may be directed to another physician within the Sedgwick CMS Medical Provider Network. **Sedgwick CMS should be contacted** at **(866) 247-2287 for authorization of treatment after the first visit**. Providers are to provide evaluation and treatment under the guidelines of the Sedgwick CMS Medical Provider Network and Administrative Director as noted in Labor Code 4600. 4616, 4616.1-7.

MPN Provider _____ Phone # _____

Address _____

Doctor – Please note the Los Angeles Unified School District requires that any work restrictions be outlined, as every effort will be made to provide modified work.

sedgwick

tmesys®

First Fill
Temporary Pharmacy Card

Making it easy to get your workers' compensation prescriptions filled.

Just follow these easy steps…

Employer:

Print this page immediately upon receiving notice of injury, fill in the information below and give it to your employee. Include your signature below.

Injured Employee:

1. If you need a prescription filled for a work-related injury or illness, go to a Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

tmesys®
Prescription Card

sedgwick

Los Angeles Unified School District

CARRIER	EMPLOYER
Sedgwick	Los Angeles Unified School District

INJURED WORKER NAME

EMPLOYEE NUMBER | DATE OF INJURY

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid within 30 days of your date of injury. For information regarding the program or to find nearby pharmacies call **866.599.5426.**

Attention Pharmacists: Call **800.964.2531** to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker.
LAUSD Issuer Name: _____

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(To create a card for your wallet, cut along outer line and fold in half.)

Pharmacist:

1. Call the Tmesys Pharmacy Help Desk at **800.964.2531.**
2. Provide the information listed above.
3. The Help Desk will provide an ID number for adjudication.

Finding a Network Pharmacy

Use one of these easy methods to find a network pharmacy:

- Visit one of the following pharmacy chains:

Walgreens	**Walmart**	**Duane Reade**	**Publix**
Rite Aid	**CVS**	**Kroger**	**Safeway**

- Use our pharmacy locator online: **www.pmsionline.com/pharmacy-center**.
- Call us: **866.599.5426**

tmesys®

Tmesys Retail Pharmacy Network*

More than 60,000 pharmacies, including large chains and many neighborhood independent pharmacies, meaning that your prescription can be filled at most pharmacies nationwide.

Accredo Health Group
Anchor Pharmacy
Arrow Prescription Center
Aurora Pharmacy
Baker's Pharmacy
Bartell Drugs
Bashas' United Drug
Bel Air Pharmacy
Big Y Pharmacy
Biggs Pharmacy
Bi-Lo
Bi-Mart
Bioscrip Pharmacy
BJ's Pharmacy
Brookshire's Pharmacy
Bruno's Pharmacy
Buehler's Pharmacy
Caremark Pharmacy
Carle Rx Express
Carrs Quality Center
City Market Pharmacy
Clinic Pharmacy
Coborn's/Cash Wise
Concord Drugs
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
D&W Pharmacy
Dahl's Pharmacy
Dierbergs
Dillon Pharmacy
Discount Drug Mart
Doc's Drug
Dominick's Finer Foods
Drug Emporium
Drug Mart
Drug Town
Drug Warehouse
Drugs For Less
E. W. James Pharmacy
Eagle Pharmacy
Eaton Apothecary
Econofoods Pharmacy
Edwards Pharmacy
Fagen Pharmacy
Family Drug Store
Family Fare Pharmacy
Family Pharmacy
Familymeds Pharmacy
Farm Fresh Pharmacy
Farmer Jack Pharmacy
Food 4 Less Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Food Town Pharmacy
Food World Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fruth Pharmacy
Fry's Pharmacy
Gemmel Pharmacy
Gentiva Health Services
Genuardi's Pharmacy
Gerbes Pharmacy
Giant Eagle Pharmacy
Giant Pharmacy
Glen's Pharmacy
Good Day Pharmacy
Grand Union Pharmacy
Gristedes Pharmacy
H-E-B Pharmacy
Haggen Foods
Hannaford
Happy Harry's
Harmons Pharmacy
Harps Pharmacy
Harris Teeter
Hartig Drug
Harvest Foods Pharmacy
Harveys Supermarket Pharmacy
Hen House Pharmacy
Hi-School Pharmacy
Homeland Pharmacy
Hometown Pharmacy
Hy-Vee Pharmacy
Ingles Pharmacy
Kmart Pharmacy
Kerr Drug
King Kullen Pharmacy
King Soopers Pharmacy
Kings Pharmacy
Kinney Drugs
Klingensmith's
Knight Drugs
Kohl's Pharmacy
Kohll's Pharmacy
Kopp Drug
Kroger Pharmacy
Lewis Pharmacy
Lifechek Drug
Longs Drug
Louis and Clark
Lowes Marketplace
Marc's Pharmacy
Marsh Drugs
Martin's Pharmacy
May's Drug Store
Med-Fast Pharmacy
Medical Arts Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy (various)
Med-X Drug
Meijer Pharmacy
Minyard Pharmacy
Morton Pharmacy
Mr. Discount Drugs
Navarro Discount Pharmacies
NeighborCare Pharmacy
No Frills Pharmacy
Network Pharmacy
Owens Pharmacy
P&C Food & Pharmacy
Pamida Pharmacy
Park Nicollet Pharmacy
Pathmark Pharmacy
Pavilions Pharmacy
PharmaCare Pharmacy
Pharmacy Express
Pharmacy Plus
Pick 'N Save Pharmacy
Piggly Wiggly
PrairieStone Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy
Q Pharmacy
QFC Pharmacy
Quality Markets Pharmacy
QuickChek Pharmacy
QVL Pharmacy
Rainbow Pharmacy
Raley's Drug Center
Ralphs Pharmacy
Randalls Pharmacy
Reasors Pharmacy
Red Cross Pharmacy
Rite Aid Pharmacy
Ritzman Natural Health
Rosauers Pharmacy
RXD Pharmacy
Sack 'n Save Pharmacy
Safeway Pharmacy
Sam's Pharmacy
Save Mart Pharmacy
Save-Rite Pharmacy
Schnucks Pharmacy
Scolaris Pharmacy
Sedanos Pharmacy & Discount
Shaw's Pharmacy
Shaws/Osco Pharmacy
Shop 'n Save Pharmacy
Shopko Pharmacy
Shoppers Pharmacy
ShopRite Pharmacy
Snyder Drug Emporium
Southern Family Market
Star Pharmacy
Stop & Shop Pharmacy
Sunscript Pharmacy
Super 1 Pharmacy
Super D
Super G
Super Foodmart Pharmacy
Super Fresh Pharmacy
Super Rx Pharmacy
Sweetbay
The Pharm
Thriftway Drugs
Thrifty White Drug
Times Pharmacy
Tom Thumb Pharmacy
Tops Pharmacy
U-Save Pharmacy
Ukrops Pharmacy
United Pharmacy
USA Drug
Vix Pharmacy
Vons Pharmacy
VG's Pharmacy
Waldbaum's Pharmacy
Walgreens
Wal-Mart Pharmacy
Wegman Pharmacy
Weis Pharmacy
White Drug
Winn-Dixie
Yokes Pharmacy

*List subject to change. This is a partial listing only.

Attachment C

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ ☐ a.m. ☐ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    Sedgwick CMS, Inc. P.O. Box 14623 Lexington, Kentucky 40512-4623
15. Insurance Policy Number. *El número de la póliza de Seguro.* N/A Self-Insured
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

Los Angeles Unified School District
Workers' Compensation Injury Report Worksheet
Call 1-800-LAUSDWC (1-800-528-7392)

Employee's Assigned Location	Location Code
Date of Incident	Time of Incident AM/ PM
Time Employee began work AM/ PM	
Date Incident Reported to District	Time Incident Reported to District AM/ PM
Name and Title of person to whom incident reported	Date an Employee Claim Form was provided to employee
Caller's Name/Title	Caller's Phone Number
State Unemployment Insurance Account Number **942-5052**	

Claimant Information

Employee Name	Employee ID #
Employee SS#	Employee Title
Work Phone	Home Phone Cell Phone
Home Address	Date of Birth _____ Date of Hire _____ Date of Termination (If Any)
Full Time ☐ Part Time ☐	Gender ☐ M ☐ F
Average number of hrs worked per day M T W Th F Sa Su	Wages : $_____ Monthly ☐ Weekly ☐ Hourly ☐
Supervisor's Name/Title	Supervisor's Phone Number/e-mail address

Incident Information

Description of Incident	
Cause of Incident (lifting, slip and fall, etc.)	Primary Body Part Injured (lower back,left/right hand, etc.)
Equipment, materials, and chemicals that the claimant was using when the incident or exposure occurred	Specific activity the claimant was performing when the incident or exposure occurred
Location where incident or exposure occurred (classroom, cafeteria, etc.)	Were other employees injured/ill in this event?
Safeguard/Safety equipment provided?	Safeguard/Safety equipment used?
Nature of Incident (strain, burn, fracture, etc.)	Was Medical Treatment Received ☐ Y ☐ N Did employee go to the Emergency Room ☐ Y ☐ N
Was Accident Investigation Completed? Yes/No	ISTAR Control Number (if available)
Name of Doctor Address of Hospital/Clinic Phone Number	Name of Hospital/Clinic
Incident Location (If different from Employee's Assigned Location)	
Witness Name/Phone Number	Witness Name/Phone Number
Last date worked:	Paid for date of injury? Yes/No
Date returned to work:	Full Duty Yes/No Modified Duty Yes/No

Additional Information

Was there medical treatment beyond First Aid?
Did the employee lose consciousness?
Did a health care professional diagnose a significant injury or illness?
Did the injury or illness involve a needle stick from a contaminated needle?
Was the employee hospitalized overnight as an in-patient?

Attachment E

Salary Continuation Benefits
Verification Form

This form is required to be completed for the first three days of absence due to an industrial injury. It is also to be completed if additional absences occur after the injured employee's return to work from an industrial injury leave. This document must be signed by the injured employee and by the physician or therapist providing treatment authorized by Sedgwick CMS. Industrial accident pay can NOT be adjusted until this form has been completed, signed and returned to Sedgwick CMS. *Please fax to Sedgwick CMS at 626- 397-9250 or mail to P.O. Box 14623, Lexington, KY 40512*

Employee's Name_____ Employee #_____

Classified☐ Certificated☐ School Police☐

Social Security Number____-___-_____ Occupation _____

Date of Injury ___/___/___ Claim number _____

Name of School or Office_____ Payroll Location Code _____

ADDITIONAL ABSENCES:

Date of Absence	**Number of Hours**	**Date returned to work**

CERTIFICATION

Under penalty of perjury the undersigned hereby acknowledges the statements made are true and factual.

Signature of injured employee _____ Date _____

Signature of physician or therapist _____ Date _____

The periods of absence shown above are hereby certified to be occasioned by authorized appointments related to an active workers' compensation claim.

Signature of Claims Adjuster _____ Date_____

NOTICE: Making a false or fraudulent workers' compensation claim is a felony subject to a maximum of 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

Updated April 2013

Los Angeles Unified School District
Workers' Compensation Program
Pre-designation of Physician Form

In the event of a work related injury or illness, I request to be treated by my personal physician. I understand this designation may only be made **before** the date of injury. I understand that I must have group health coverage for non-industrial injuries or illnesses in order to pre-designate.

The physician I selected meets the following criteria:

- Within a reasonable geographical area from my residence or work location.
- A Licensed Physician pursuant to Chapter 5 of Division 2 of the Business and Professions Code.
- Is my regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed my medical treatment, and retains my medical records.
- Agrees before the injury to be designated as my physician in the event an industrial injury occurs.

Please Note: The California Labor Code defines "Personal Physician" as a doctor of medicine, or a doctor of osteopathic medicine, who prior to the injury had directed the medical treatment of the employee and who retains the employee's medical records and medical history.

If my personal physician is not qualified to treat the injury or declines to provide treatment, my employer will direct my treatment to an appropriate physician.

Employee Name: _____ **Employee Number:** _____

Pre-designated Physician's Name: _____ Telephone No. _____

Address: _____

Employee Signature: _____ Date: _____

Site Administrator Signature: _____ Date: _____

I, _____ am a physician and I have read and certify that I meet and will adhere to the requirements listed above as the pre-designated personal physician for _____.

Physician's Signature _____ Date: _____

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1 (a)(3)

This form must be maintained at the work location in the employee's personnel file.