WORKERS' COMPENSATION FORMS
CENTRAL STORES COMMODITY CODES

Employer's Report of Occupational Injury/ Illness (5020)	7673
Authorization to Release Records (WC10)	7697
Workers' Compensation Benefit Election Form (WC-11)	7681
Employee Claim Form (DWC1)	7674
Supervisor's Report of Illness/Injury (WC9)	7672
Work Related Injury Supervisor's Checklist	7683
Workers' Compensation Designated Physicians Form	None

COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
AUTHORIZATION TO RELEASE RECORDS

PHONE (916) 874-7674 **FAX (916) 874-7015**

I, _____, hereby authorize any person in possession and/or in control of all records, including but not limited to medical, mental health, drug and/or alcohol treatment, employment, personnel, group insurance, and retirement records, to release those records to an agent, designee or representative of the County of Sacramento, Workers' Compensation Office for the purpose of photocopying, review, investigation, inspection or evaluation of any claim filed against the County of Sacramento for Workers' Compensation benefits or any other benefits or damages.

This authorization shall become effective immediately and shall remain in effect for three (3) years unless otherwise revoked in writing. Photocopies of this authorization may be used with the same force and effect as the original. I understand that I am entitled to a copy of this authorization.

Date: _____ Employee Signature _____

Date of Birth: _____

SSN _____-_____-_____

Please forward the completed form to the Workers' Compensation Office, 700 H Street, Room 6750, Sacramento, CA 95814, mail code 09-6750.

7697 (WC10) Revised 3/99

COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
BENEFIT ELECTION FORM

Background

Regular employees who are temporarily disabled because of an on-the-job injury, may elect to integrate their temporary disability benefits with their accrued leave balances. This option is also available to all individuals who have exhausted their benefits pursuant to Labor Code Section 4850.

Mandatory election

It is mandatory that you ***make an election prior to receiving your first temporary disability benefit check.*** Once your election is made and your first temporary disability check has been issued, ***the election cannot be changed.***

Option A

You may elect to have your accrued sick leave, vacation, CTO and holiday-in-lieu time integrated with temporary disability benefits. The monetary value of the temporary disability and the monetary value of the leave balance usage when added together represent the full gross pay. The number of leave balances used will vary per employee, but will never be more than one-half of the number of hours the employee is absent from work during the pay period due to the work-incurred injury or illness. During integration you will receive a partial paycheck from your department representing your accruals and a check for temporary disability benefits from the Workers' Compensation Office until all your accrued leave is exhausted. Thereafter, you will receive **ONLY** temporary disability benefits from the Workers' Compensation Office.

Option B

You may elect to use a full day of your accrued sick leave, vacation, CTO, and holiday-in-lieu time for each full day that you are absent from work due to a work related injury or illness AND receive temporary disability benefits from the Workers' Compensation Office at the same time. You would then receive BOTH your full salary and temporary disability benefits until all accrued leave time is exhausted. Thereafter, you will receive ONLY temporary disability benefits from the Workers' Compensation Office.

Election

Please elect one of the following by placing and "X" on the line next to your choice.

_____ Option A (Partial leave balance usage)

_____ Option B (Full leave balance usage)

_____	_____-____-_____	_____
Signature of Injured Worker	Social Security Number	Date

Please forward the completed form to the Workers' Compensation Office, 700 H Street, Room 6750, Sacramento, CA 95814, mail code 09-6750.

7681 (WC11) Revised 3/99

COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
SUPERVISOR'S REPORT OF ILLNESS/INJURY

Phone Number 874-7674 **Fax Number 874-7015**

PERSONAL INFORMATION: (Please print or type)

Employee Name:_____SSN:_____

Department:_____Section:_____

Number of hours worked per week:_____Time shift begins:_____Ends:_____

Normal days off:_____

Regular employee? **Yes/ No** If No, Explain:_____

Was any informal or formal personnel action considered or taken against the employee within the previous twelve months? **Yes/No**

INJURY/ILLNESS INFORMATION:

Type of Injury / Illness (Check One)	❒ Incident Report / First Aid Only	
	❒ Medical Treatment Expected	
Date of illness / injury:	Time:	Date Reported:

How was illness/injury reported? ❒ In person ❒ Phone ❒ Other
If other, explain:_____

Where did illness/injury occur? (address and city):_____

_____

Was employee performing usual job duties when injured? **Yes / No**

Did employee work after date of injury?
If yes, date returned:_____ If no, anticipated date of return:_____

Is there any reason to believe this may **NOT** be a valid claim? **Yes / No**

If incident was witnessed, provide the name(s), address, and phone number of the witness(s):
Name(s):_____Address:_____Phone:_____

If equipment or property was involved, provide the following:
Owner:_____Phone:_____
Address:_____
Insurance company:_____
Address: Phone:

TREATMENT INFORMATION:

Provided by:
❒ MedClinic ❒ Ambulance ❒ Doctor
❒ Nurse ❒ Hospital ❒ Self administered
❒ Other, please explain:_____

Name of person providing treatment: _____
Place of treatment: _____

DESCRIBE HOW THE INJURY OCCURRED: (Example: employee walking down the stairs, tripped & fell injuring right knee on the cement; employee lifting a box, felt sharp pain in lower back.)

_____
_____

BODY PART: Check appropriate box(s) and on the line provided specify the location by indicating LE for Left, RT for Right, BO for Both, FR for Front, and BA for Back.)

❒ Head/Skull___	❒ Arm____	❒ Leg____	❒ Heart____	❒ Back, Upper
❒ Nose____	❒ Elbow____	❒ Hip____	❒ Chest____	❒ Back, Mid
❒ Ear____	❒ Ankle____	❒ Foot____	❒ Lung____	❒ Back, Lower
❒ Tooth____	❒ Finger____	❒ Knee____	❒ Abdomen____	❒ Neck____
❒ Mouth____	❒ Wrist____	❒ Toe____	❒ Psyche____	❒ Eye____
❒ Shoulder____	❒ Hand____	❒ Other_____		

NATURE OF INJURY: (Check appropriate box.)

❒ Irritation/inflammation	❒ Emotional Stress	❒ Trauma/Contusion
❒ Sprain/Strain	❒ Heart	❒ Puncture/Laceration
❒ Repetitive Motion	❒ Bite	❒ Abrasion
❒ Fracture	❒ Exposure (To what) _____	
❒ Other_____		

CAUSE OF INJURY/ILLNESS: (Check appropriate box.)

❒ Design of workstation/building	❒ Uneven or slippery surface
❒ Rules/procedures not followed or inadequate	❒ Horseplay
❒ Incorrect body position in relation to work	❒ Exposure (chemical, noise, etc.)
❒ Incorrect tools or mechanical aids used	❒ Vehicle operation
❒ Equipment operated incorrectly)	❒ Congested area (storage)
❒ Environmental factors (weather, lighting)	❒ Animal or insect
❒ Action of fellow employee/member of public	❒ Conflict with supervisor
❒ Protective devices or guards	❒ Inattention or distraction
❒ Other (please explain)_____	

SOURCE OF INJURY (Check appropriate box.)

❒ Structure	❒ Equipment/Tools	❒ Material
❒ Objects	❒ Environment	❒ Person
❒ Other_____		

PREVENTATIVE MEASURES (Check one or more actions.)

❒ Provide more complete job instruction	❒ Update or revise procedures
❒ Enforce work rule	❒ Provide safe equipment
❒ Provide proper tools, equipment	❒ Reinforce employee training
❒ Provide personal protective equipment	❒ Modify workstation or building
❒ Contract third party to effect correction	
❒ Other (please explain)_____	

Prepared by :_____/_____

(Supervisor's Signature) **(Please Print Name)**

Phone:_____ **Date:**_____

Please forward <u>this completed form along with your department's 5020 form,</u> within 24 hours after incident, to the Workers' Compensation Office, 700 H Street, Room 6750, Sacramento, CA 95814, mail code 09-6750.

7672 (WC9) Revised 3 99

County of Sacramento
WORKERS' COMPENSATION OFFICE
WORK RELATED INJURIES/ILLNESSES
SUPERVISOR'S CHECKLIST

As a supervisor, you must convey the message that you care about your employees both before and after work injuries occur.

PREVENTION OF INJURIES:
Safety is a key to reducing injuries, thereby, controlling workers' compensation costs.

❒ Provide safety orientations, training, and regular meetings covering operations and hazards of each job as required by state law.

PRIOR TO INJURY:
At the time of hire, employees are provided with a "Workers' Compensation Designated Physician Form". The purpose of the form is to allow employees the right to choose a physician to treat them in case of industrial injuries. Anytime after the date of hire supervisors must:

❒ Upon request from the employee, provide a "Workers' Compensation Designated Physician Form". Accept requests for designated personal physicians anytime prior to injury.

❒ Forward the personal physician designation form to the Workers' Compensation Office, mail Code 09-6750.

AFTER THE INJURY:
When the supervisor receives notice or has knowledge of a work related injury or illness, he/she must:

❒ Determine the Worker's immediate medical needs and arrange for treatment. Administer first aid, if required, or IN CASES OF A SERIOUS ACCIDENT OR INJURY: 1) DIAL 9-911 to dispatch emergency personnel, and 2) contact the Workers' Compensation Office at 874-7674.

❒ Refer the employee to the nearest Medical Clinic of Sacramento, Inc. (MedClinic) for treatment if the injury is not serious and there is no "Workers' Compensation Designated Physician Form" on file.

❒ Notify the Workers' Compensation Office (874-7674) and the injured worker's relatives or emergency contact person if the injury is serious.

Supervisor's checklist ***(continued) 2 of 3***

❒ Identify the cause of the injury or illness and take the necessary steps to secure the workplace to avoid further injury.

❒ If equipment was involved in the injury (broken chair, ladder, machinery, vehicle, etc.), take necessary steps to secure the evidence.

FIRST AID INJURY:
If the injury or illness required only first aid treatment and there was no medical treatment required, the supervisor must:

❒ ***Complete only the Supervisor's Report of Injury/Illness Form (WC 9) within 24 hours*** of injury and forward the completed form to the Workers' Compensation Office.

MEDICAL TREATMENT INJURIES/ILLNESS:
If the injury or illness results in lost time beyond the date of injury or requires medical treatment beyond first aid, the supervisor must:

❒ **Within one working day** of notice or knowledge of incident, complete line 1 and the employer section with the exception of line 13 of the Employee Claim Form (DWC-1).

❒ Remove the gold copy (Workers' Compensation Office Acknowledgment) of the Employee Claim Form (DWC-1).

❒ Provide the worker (or his/her dependents or agent) **within one working day** with the remaining copies. The form may be delivered personally or by first-class mail.

Completion of the remainder of the claim form is the responsibility of and at the discretion of the employee.

❒ Provide the worker with the "Authorization to Release Records" form.

❒ Provide the worker with the "Benefit Election" form.

❒ Collect all information about the injury. Note when, where and how the incident occurred and names of witnesses. Obtain the worker's account of the incident.

❒ Complete the Supervisor's Report of Injury / Illness (form WC9).

❒ Complete the Employer's First Report of Injury / Illness (form "5020").

Supervisor's Checklist *(continued)* 3 of 3

❒ Forward the gold copy of the DWC-1, the Supervisor's Report of Injury / Illness, and the 5020 form to the Workers' Compensation Office (09-6750).

❒ Upon return of the claim form, make sure the employee has removed the pink copy ("Employee's Temporary Receipt") of the Employee Claim Form (DWC-1).

❒ **Within one working day of receipt of this claim form** from the employee, complete the remainder of the employer section and provide the yellow copy to the employee. Forward the remaining white (original) copy to the Workers' Compensation Office (09-6750).

ON-GOING:
Communication is a key to controlling workers' compensation costs and assuring timely recovery from work injuries.

❒ Contact the employee a few days after the injury to answer questions and determine any special needs or problems.

❒ Maintain contact with the injured worker and the claims adjuster regarding the status of the claim.

❒ Provide reasonable job accommodations to the injured worker.

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COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
DESIGNATED PHYSICIANS FORM

In case of an on-the-job injury, I wish to be treated by my personal physician: (Please print or type.)

Name of Employee: _____ **County Department:** _____

Social Security Number: _____Work Phone: _____

Work Address: _____Mail Code: _____

Doctor and/or HMO Provider: _____

Doctor's Address: _____

City: _____State: _____Zip Code: _____

Doctor's Telephone Number: _____

Employee's Signature: _____Date: _____

Please forward this completed form to the Workers' Compensation Office, 700 H Street, Room 6750, Sacramento, CA 95814, mail code 09-6750.

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