

Workers' Compensation Procedural Manual  
for the  
Southeast Municipal Court

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Institute for Court Management  
Court Executive Development Program  
Phase III Project  
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## GLOSSARY

## Acknowledgments

After attending Phase II of the Executive Development Program held in Williamsburg, Virginia, I felt this project was overwhelming. By separating the project into portions, it was easier to complete and not as overwhelming as originally thought.

I wish to thank my husband, Harvey for all his encouragement during the preparation of this project. He put our weekend hobbies on hold to allow me the time for research and data entry.

I appreciate the members of my church for excusing me from regular church attendance because I was working on the project. I thank them for their understanding.

A special thanks to the Judges of the Southeast Municipal Court, co-workers, peers, and staff at other County facilities that shared copies of their procedures. I will never forget their generosity and unselfishness. Thanks also to friends and peers that have completed the Fellowship Program that offered encouraging words during off-peak periods.

## Introduction

This manual was prepared for the Managers and Supervisors of the Southeast Municipal Court. No written policy and procedures were available to deal with an employee who suffered an on-the-job injury. Basic guidelines were followed as to where to refer the injured employee, but no knowledge of what happens afterward and why the procedure takes so long to be resolved.

It is our hope that this manual will provide additional information relative to the process and the expected length of time necessary in processing worker's compensation cases.

If it is possible to prevent a problem from occurring, it is hoped that by reading and following this manual the number of injuries/illness will be diminished.

The Court is located within the County of Los Angeles, on the Southeast portion. The District has two locations, one in the City of Huntington Park and the other in the City of South Gate. The District has coordinated with the Administratively Consolidated Municipal Courts. The APMC has a total of eight locations with a total of six Judicial Districts. APMC consist of the following courts:

Compton

Lynwood Regional Justice Center

Downey

Los Cerritos

Southeast

Huntington Park

South Gate

Santa Anita

Whittier

The final product will be distributed to all supervisors within the Southeast Judicial District to read and implement. Monthly meetings will be conducted to determine if the manual answers some of the supervisor's questions. It is the intent of this manual to reduce the number of filings and to return our employees to work as quickly as possible.



## **Bibliography**

**A Guide to Recordkeeping Requirements for Occupational Injuries & Illness**

**U.S. Department of Labor Bureau of Labor Statistics**

**Government Code Sections relative to Disability Retirement**

**Los Angeles County Directory of Physicians and Medical Facilities for INDUSTRIAL  
INJURY**

**1996 Analysis of WORKERS' COMPENSATION LAWS, Prepared and Published by the  
U.S. Chamber of Commerce**

## Abstract

This manual provides overview of the procedures that must be adhered to in the filing and investigating of a work-related injury or death of an employee. The Court has incurred a number of Workers' Compensation related injuries and the supervisors have not had the skills necessary to provide enough information to the Third Party Claims Administrator to properly assess the case. It is generally felt that attitudes and prejudices automatically occur against an employee that files a claim. The job of a supervisor extends to an injured employee and the County of Los Angeles and Return to Work Coordinators feel that employees would return to work quicker if supervisors showed more interest in their recovery and well being.

There is information in print from the employee's viewpoint, but not as much from an employers viewpoint. Information was requested from several departments within the County of Los Angeles, including the Disability Benefits Division. Some of these departments willingly shared what was available. Some of the materials were prepared in the late 1980's and have not been updated. It appears that the majority of these departments have staff with individual knowledge without having to follow written guidelines.

It is therefore the conclusion that the Southeast Municipal Courts needs a procedural manual to act as a guideline for the equitable treatment of all persons injured within our judicial district. This manual includes information not limited to the following:

- How Control of Workers' Compensation Claims Can Be Lost
- Employee Responsibilities
- Duties of the Employee Selected Physician
- Responsibilities of the Immediate Supervisor
- Know The Medical Facility In The Area
- Referring Employees For Medical Treatment
- Medical Service Order
- Reporting Occupational Injuries to Claims Administrator

The Manual should be updated yearly in order to keep abreast of changes that affect workers' compensation laws.

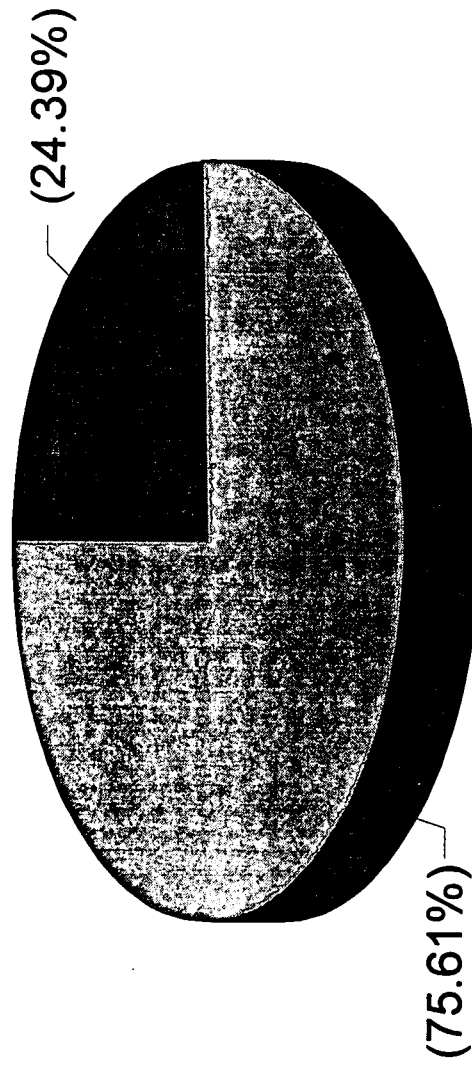
## **PURPOSE**

The purpose of this Workers Compensation Manual is to provide, through a team approach, a comprehensive Workers' Compensation program which will be followed by the Managers/Supervisors of the District through implementation of preventative and cost containment programs that have measurable value.

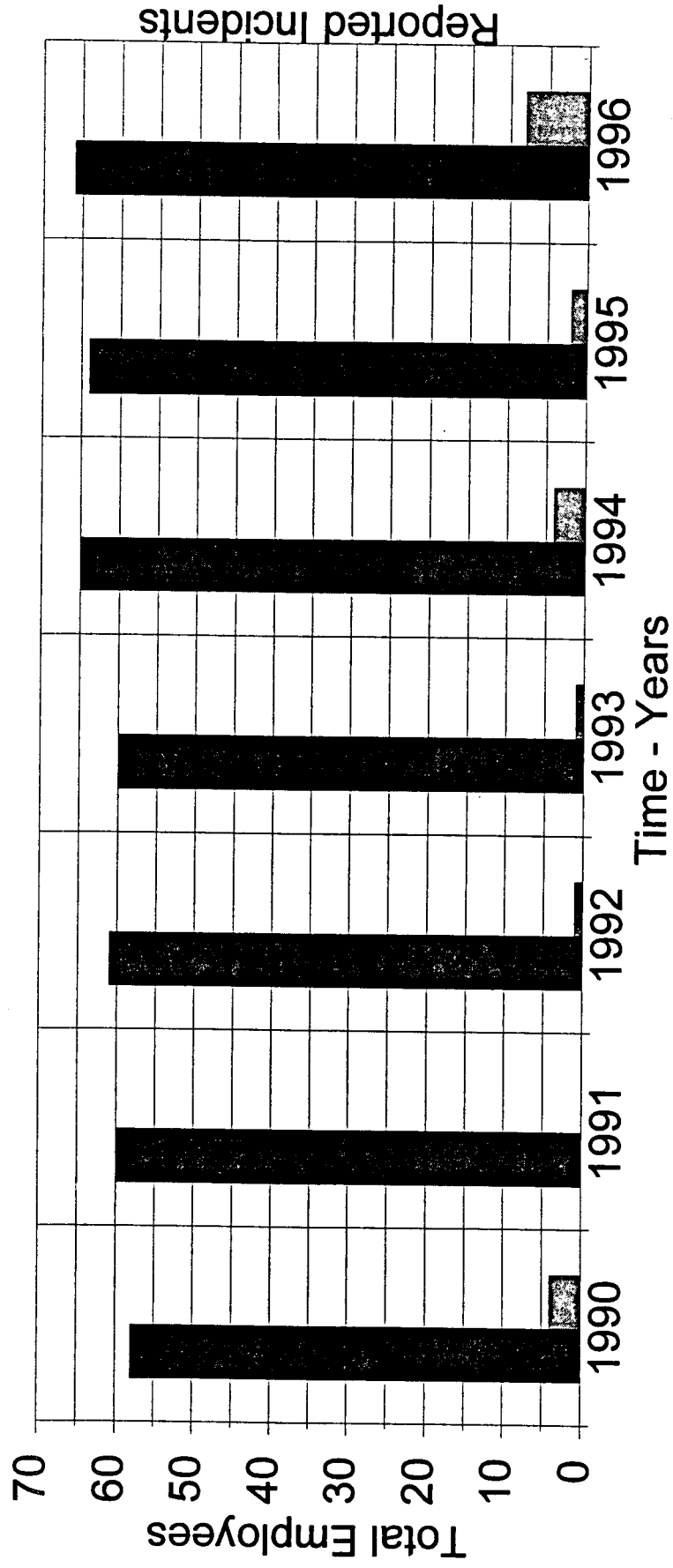
Workers' Compensation cases within the Southeast Municipal Court seem to be rising in terms of the number of incidents claimed over the last few years. Therefore, this leads to the conclusion that the District needed a manual for its Supervisors to act appropriately and to minimize claims for benefits.

# Open Workers Compensation Cases

Total Cases (1990-1996)



# Open Workers Compensation Cases



# How Control of Workers' Compensation Claims Can Be Lost

1. Lack of interest in the employee and his/her injury.
2. Failure to contact the employee early.
3. Failure to maintain friendly and periodic contact with the employee.
4. Failure to explain the employee's rights to him/her.
5. Failure or delay in paying a medical bill.
6. Dissatisfaction with medical treatment.
7. Delayed benefit checks.
8. Lack of consideration in job placement or return to work

## **TYPES OF BENEFITS**

1. Medical Benefits
2. Total Temporary Disability Benefits
3. Permanent Disability Benefits
4. Vocational Rehabilitation
5. Death Benefits

## **TYPES OF INJURIES NOT COVERED BY WORKERS' COMPENSATION**

1. Initial Physical aggressor.
2. Off-duty recreational activities not related to employment.
3. Self-inflicted injury.
4. Conviction of Felony.
5. Intoxication
6. Suicide

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## CHAPTER 1: EMPLOYEE'S RESPONSIBILITIES .....

### A. On-the-Job Injury/Illness: (Not life threatening)

#### 1. Non-Emergency Treatment.

- a. Report the injury/illness and its causes no matter how minor the injury, immediately or as soon thereafter as possible, to your supervisor.
- b. If medical treatment is necessary, select a physician or medical facility near the office or near your home from which to obtain treatment from the Directory of Physicians and Medical Facilities for Industrial Injury prepared by the County of Los Angeles. (RIMA)

Note: If you obtain a non-emergency medical treatment from a physician or medical facility not included in the directory, you assume responsibility for the cost of such treatment, unless you follow the procedure in (c) below.

- c. You may elect to be treated by your personal physician if you have on file prior to your injury, an Industrial Injury Designation of Personal Physician (See Appendix No 18). Before leaving the job site for medical care always call first to ensure the physician will be able to treat your injury immediately.

Note: When designating your personal physician to provide medical treatment in the event of industrial injury/illness, ensure the doctor is willing to submit to a timely manner required reports and itemized bills to the Third Party Claims Administrator.

Failure of your physician to submit required reports may result in delay or denial of liability for compensation benefits.

- d. Before you leave the work site, your supervisor will give you a signed and partially completed Medical Service Order (Appendix No. 19 ), which authorizes your medical treatment. It is your responsibility to deliver this Medical Service Order to the physician, ensure the physician completes the necessary portions of the form, and return the form, or arrange for its return, to your supervisor. The physician will determine if you are able to return to work immediately or if any work restrictions are needed to allow you to return to work..
- (1) You will be given a "Employee's Claim for Worker's Compensation Benefits" form (Appendix No. 7) your supervisor will ask you to sign and date a log that you received this form..
- (2) You are not mandated by law to return the form to your supervisor. If you decide to return the form, your supervisor will mark the form "temporary receipt" and return a copy to you. The Division Chief/Return-to-Work Coordinator will mail you a signed form.
- e. If you are unable to contact your supervisor or another supervisor in your division regarding the injury/illness, call the Division Chief/Return-to-Work Coordinator at (213) 586-6353 for the Huntington Park Office or (213) 563-4011 for the South Gate Office, who will authorize the necessary treatment and assist you in selecting a medical facility. If the RWC also is unavailable, go to the nearest medical facility listed in the Directory of Physicians.
- f. If the physician releases you to return to work immediately, you must return at that time. If the physician releases you with work restrictions, your supervisor and the RWC will review your current assignment to see if it is compatible with the restrictions or will endeavor to arrange for an assignment compatible with the restrictions. The

physician's determination regarding your ability to perform your duties or modified assignment is essential.

- g. Any absence beyond the time or date of release to return to work by the treating physician may not be covered by Worker's Compensation or other sick leave benefits and is subject to disciplinary action.
- h. If you decline medical treatment, you will be asked to sign a statement (Appendix No. 6 ) acknowledging your refusal and stating your reasons. You do not waive your rights to subsequent treatment by this action and, if at a later date, medical care is required for the injury/illness, notify your supervisor promptly.

**B. On the Job Injury - Emergency Treatment (life threatening)**

- 1. In the event of serious or life threatening injury / illness, call the paramedics or other emergency medical service --or-- go to the nearest facility for treatment even if that facility is not listed in the Directory of Physicians. Do not delay for paperwork.
- 2. If circumstances of the emergency do not permit a Medical Service Order to be given to the treating physician, the Return to Work Coordinator/Division Chief will have the physician or the medical facility complete a Medical Service Order.

If subsequent medical treatment is necessary, following emergency medical care, you must use a physician or medical facility listed in the Directory, or your personal physician, if you have completed the required Industrial Injury designation of Personal Physician. If there are any questions in this regard, call the Division Chief at (213) 586-6353 (Huntington Park) or (213) 563-4011 (South Gate).

## **C. Follow-up Medical Treatment**

1. If your physician says you will need further treatment, inform your supervisor of each appointment and use a follow-up Medical Report (Appendix No. 11 ) for each required visit. This form must be completed and signed by the Physician at the time of each subsequent examination. Return this completed form to your supervisor, or, if you are unable to do so, arrange for it to be delivered to your supervisor or the RWC.

If the physician tells you he wants to refer you to a specialist, ask the physician first to call the Third Party Claims Administrator at (800) 782-5888.

2. If you wish to change physicians for follow-up treatment, you may do so no sooner than thirty (30) days after the report of your injury. The change may be to your personal physician, even if you have not completed a Request for Treatment by Personal Physician. You will need the name address, and phone number of the physician. Contact the Third Party Claims Administrator with this information. All follow-up visits require the completion of a follow-up Medical Report.
3. All follow-up Medical Reports and any statement or letter from your physician regarding disability, work restrictions, or release to return to work must be returned immediately to your supervisor.
4. In the event you are disabled for more than one week, call your supervisor at least every week and report your condition. This will assist your supervisor in planning for the performance of your duties during your absence.
5. When you are required to be off work for an extended period, the Division Chief/Return to Work Coordinator will contact you to explain Worker's Compensation benefits and

the Department's return to work opportunities and to answer any questions you may have.

6. If you have a recurrence of a previous on-the-job injury, inform your supervisor, who will call the Division Chief to arrange for medical treatment.

**D. Permanent Disability.**

If an on-the-job injury / illness results in permanent disability and permanent work restrictions issued by the Third Party Claims Administrator, the Division Chief will inform you of options and assist you in obtaining appropriate benefits. Depending on the nature and extent of the disability and work restrictions, these may include:

1. Rehabilitation through the Third Party Claims Administrator.
2. Transfer to a different position in the Court or another department.
3. Voluntary demotions in the Court or another department. Employees in Retirement plans A-D may be eligible for salary supplements from the Retirement Board.
4. Retirement through applicable disability provisions.

**E. Non-Job Related Injury / Illness**

1. Should you experience non-job related injury / illness which will prevent you from performing your normal duties, inform your supervisor as soon as practicable, but no later than thirty minutes (30) following the start of your next work period.
2. Should a non-job related injury / illness disable you for one week or more, call your supervisor weekly and report your condition. This will assist in planning for the performance of your duties in your absence.
3. Forward copies of all letters or statements from your physician regarding your condition and the expected duration of your disability to your supervisor.

4. Any statements by your physician regarding work restrictions or physical limitations regarding work performance should be sent immediately to your supervisor.

**F. Return to Work**

Before you will be permitted to resume your work duties following your disability, you must give your supervisor a statement from your physician indicating you are able to return to work.

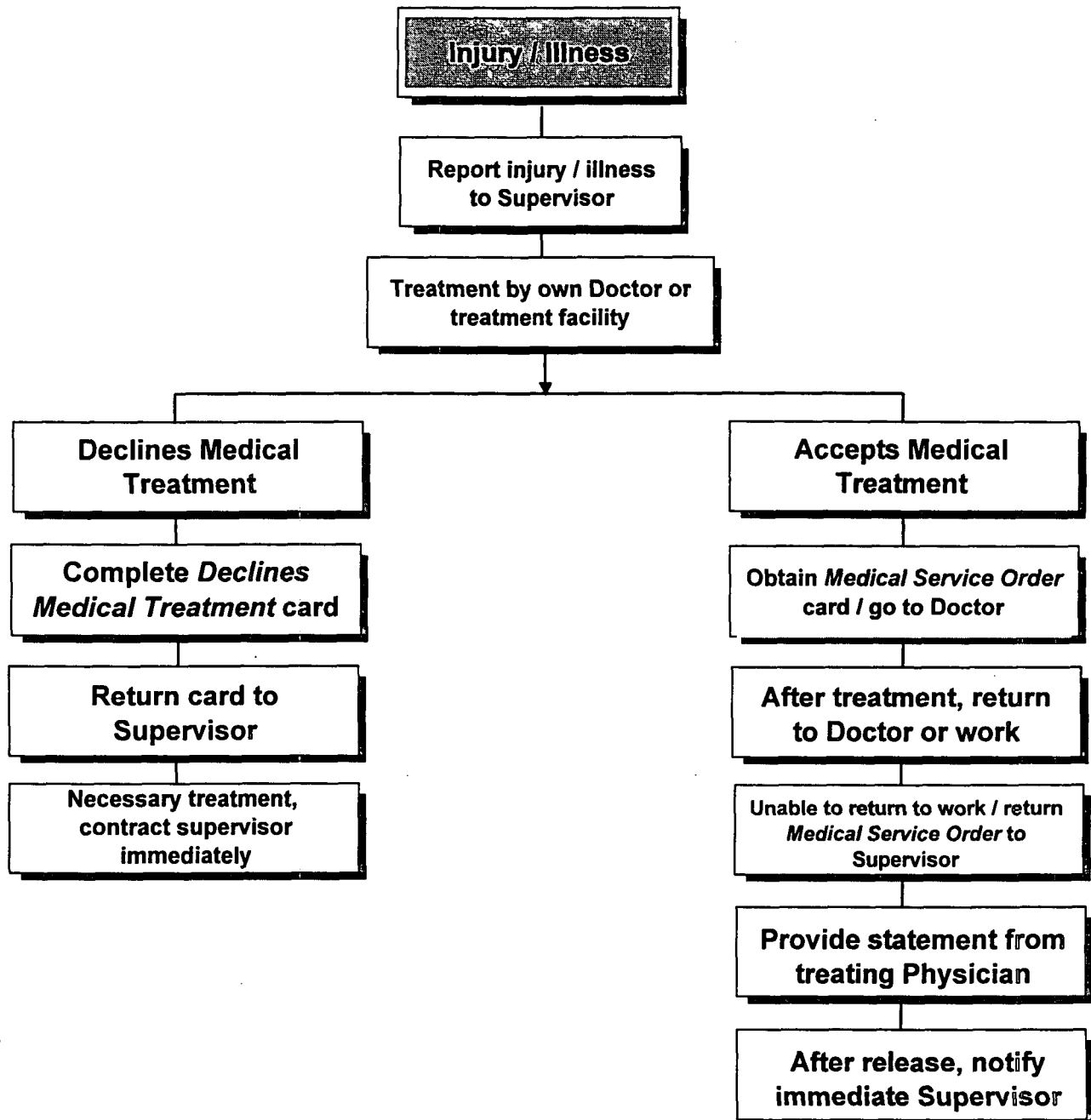
Before permitting you to resume your normal duties or to perform a modified assignment, the Court may require you to be medically evaluated.

1. You will be asked to sign a statement permitting a Contracted Medical Facility to review your medical records with your personal physician. Such review is held in strict medical confidence.
2. To facilitate your early return to work, it is important to arrange for this review as far in advance of your anticipated return to duty as is possible. Necessary arrangements will be made by the Division Chief.
3. If your non-job related injury / illness results in a need for a lengthy recuperative period, you may be allowed to return to work on a modified assignment prior to resuming your full, normal duties.
4. Before you will be permitted to assume a modified assignment, your physician must provide the Court with a detailed description of your restrictions.
5. Such modified assignment will be designated to assist in your recuperation and return to full duty.
6. Such modified assignment may be terminated if the department no longer needs the services of the assignment or your medical

condition is declared by a physician to be permanent and stationary and permanent work restrictions are imposed.



EMPLOYEE'S RESPONSIBILITY



1

2

1

## **CHAPTER 2: PHYSICIANS RESPONSIBILITIES .....**

### **A. Procedures**

1. The physician or facility chosen by the employee who undertakes to provide treatment pursuant to Labor Code Section 4600 shall:

Within 3 working days after undertaking to provide such treatment notify the employer of the name and address of such treating physician or facility, and

2. Within 5 working days following initial examination submit a written report to the employer to include:

- a. The name and address of injured employee;
- b. The employee's medical history or obtained by the physician, including any significant prior injuries or disabilities;
- c. Findings on examination, including the objective findings, the subjective complaints reported by the employee, and the diagnosis including any applicable ICD-9-CM Number;
- d. The planned course, scope, frequency and duration of treatment, including an estimate date of completion of treatment.
- e. If appropriate, the estimate return-to-work date for regular or modified work;
- f. An opinion as to whether residual permanent disability is to be anticipated and, if possible, any estimate of its extent;
- g. An opinion as to whether the employee will eventually be able to engage in the occupation performed at the time of injury.

Information required under this subdivision which is included in a "Doctor's First Report of Occupational Injury or Illness" submitted pursuant to Section 14007 may be supplied by attaching a copy of this form to the report.

3. Submit progress reports no less frequently than every 45 days or 12 visits with the physician or a provider prescribed by the physician, whichever occurs first
4. Report promptly to the employer when:
  - a. The employee's condition permits return to modified or regular work;
  - b. The employee's condition requires him/her to leave work;
  - c. Hospitalization or surgery is indicated or recommended;
  - d. The employee's condition becomes permanent and stationary;
  - e. The employee's condition undergoes a previously unexpected significant change or there is any significant change in the treatment plan reported under paragraph (4) of subdivision (b). This report shall contain any information required in the initial report under subdivision (b) which has changed, including any change in the proposed course, scope, frequency and duration of treatment and estimated date of completion of treatment;
  - f. The employee is referred to another physician for consultation;
  - g. The employer reasonably request additional appropriate information;
  - h. The physician concludes that the employee's permanent disability precludes or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of injury, as required pursuant to Labor Code Section 4636(b).
5. When required under section 978.5, provide a report of findings of permanent disability, in the manner set forth in that section.
6. Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, which ever is appropriate.

## **B. CHOICE OF PHYSICIAN**

Section 4600 of the California Labor Code provides that any employee has the right to be treated by his personal physician for an industrial injury, if he/she has notified the employer in writing (Worker's Compensation; Notification to New Employee form) of the name and address of the physician prior to sustaining an injury. The original will be placed in the Official Personnel File in the Personnel Office. Retain a copy in your divisional file. A personal physician is defined directed medial treatment of the employee, and who retains the employee's medical records.

For this purpose, "personal physician" means the employee's regular Doctor of Medicine (M.D.) or Doctor of osteopathy (D.O.), licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. (Labor Code Section 4600)

If you are still receiving necessary medical treatment 30 days or more after you reported your injury, you may select your own doctor or medical facility within a reasonable geographic area. Even though you have the right to change doctors, you may feel that continuing with the same doctor is best for you. You may want advice about medical specialists. We suggest you talk with the third party Claims Administrator before you act. If you make a change, you should immediately notify your Claims Administrator of the name and address of the doctor or facility. (Labor Code Section 4600)

State law requires your doctor to send a medical report to the Claims Administrator within five days after his first examination, and periodic reports thereafter. Itemized bills, including current RVS (Relative Value Studies) codes, should be addressed to the Claims Administrator, not the patient. Be sure your doctor is willing to submit these required reports and to cooperate with the Claims Administrator to secure your recovery and return to work. Failure of your doctor to report may result in the delay, or denial, of liability for compensation benefits. All reports and bills should be sent to the Claims Administrator.

No benefits will be authorized until the Claims Administrator receives all appropriate information. Whether or not the employee chooses to see his own physician, a "Medical Service Order" must be issued.

An employee who chooses to change doctors after 30 days must immediately notify the Claims Administrator carrier.



## CHAPTER 3: SUPERVISOR'S RESPONSIBILITIES .....



### A. Procedures

1. The Supervisor of an employee who has an industrial accident or injury has the responsibility to:
  - a. Issue the form DWC 1, Employee's Claim for Workers' Compensation Benefits to an industrially injured employee within one working day of the Department's knowledge of the employee's injury / illness or upon the request of the employee or his representative, whichever occurs first, in accordance the Courts procedures.
  - b. Offer medical services when an employee reports an industrial injury and desires medical treatment.
    - (1) If the employee has not predesignated a doctor prior to injury / illness, a treating professional shall be selected from the Directory of Physicians.
    - (2) If the employee has predesignated his own treating professional prior to the injury, he may be treated by that doctor or a doctor listed in the Directory.
    - (3) If an employee claims a subjective illness (stress and strain, headache, high blood pressure) as a result of his work, a Medical Service Order shall not be issued to the employee. (See Section V Subjective Illnesses, Page 35)
  - c. Have the employee complete the Employee's Statement Declining Medical Treatment if medical services offered and refused (even if employee goes to a physician other than in the directory or as predesignated).
  - d. Prepare the top part of the Medical Service Order, and give it to the employee, telling him that the form should be completed and signed by the doctor at the time of the first visit to the doctor. The employee shall



be instructed to return the completed form promptly to the Supervisor / Division Chief either personally or by mail. The Division Chief sends the Medical Service Order to Human Resources located in the Downey Municipal Court.

- e. Take the employee or arrange to have the employee taken to a doctor in emergencies involving serious injury.
- f. Prepare Employer's Report of Occupational Injury / Illness (three copies) within 24 hours from the date of knowledge of the injury / illness. One copy should be filed in the office personnel folder; original to APMC Human Resources along with Medical Service Order or Employee's Statement Declining Medical Treatment.

## **B. Procedures for Employee's Claim for Worker's Compensation**

The supervisor of an employee who reports an industrial injury shall issue the form DWC 1, Employee's Claim for Workers' Compensation Benefits within one working day of the Courts/Department's knowledge of the employee's injury / illness upon the request of the employee or his/her representative whichever occurs first.

### **1. Definition of Notice or Knowledge:**

Under the Workers' Compensation laws, knowledge or notice of an industrial injury occurs when knowledge of the occurrences of an industrial injury is obtained from any source on the part of an employer, its managing agent, superintendent, foremen, or other person in authority or knowledge of the assertion of a claim of injury / illness sufficient to afford the opportunity to the employer to make an appropriate investigation into the facts.

- 2. If it is not feasible to hand deliver the form to the employee within one (1) working day, send by first-class mail to the employee's last known address within one (1) working day. Prepare a (Proof of Service by Mail" to document timely mailing of the Claim Form. (See Appendix No. 18)

3. Division Chief and ACMC Human Resources shall maintain an Industrial Injury Claim Form Log. (See Appendix No. 17) This form shall be annotated by the Division Chief upon the issuance of the claim form to the employee by entering the employee name, employee number, and the date the claim form was given or mailed to the employee or employee representative.
4. Upon the return of the completed claim from by the employee, date stamp it. The form is completed when it is signed and dated. Mail copy to Human Resources.
5. The Division Chief shall complete the Employer's Section (Item 8-15) of the claim form.
6. The completed claim from shall be distributed as follows:
  - (a) Original to the employee as a receipt;
  - (b) One copy to the employee's Official Personnel Folder (Industrial Injury File;
  - (c) One copy to ACMC Human Resources located in the Downey Municipal Court.
7. The Industrial Injury Claim Form Log shall be reviewed by the Court Administrator to ensure that it has been annotated to reflect completion of each of the above activities.

**C. Responsibility of Supervisor Regarding Returning to Work Employees**

1. A returning employee's Supervisor has the responsibility to:
  - (a) Obtain from the employee immediately upon return to work regardless of the length of absence, a written statement from the treating professional indicating that the employee is released to return to work, with or without restrictions, any modification of duties, full or part-time.

- (b) Contact the Human Resources Department and Administration to discuss any work restrictions, proposed modification of job duties, full or part-time.
- (c) Contact Human Resources if there is any reason to question an employee's ability to resume the duties of their position without hazard to themselves or others.
- (d) Forward a copy of return to work slip to the Human Resources Department of ACMC. 7500 Imperial Highway, Downey, CA
- (e) Report by telephone to Human Resources if the employee goes off work again after returning if the leave is related to the employee's industrial injury / illness. Forward a copy of the doctors statement taking him off work, to the Human Resources Department.

#### **D. Approved Medical Treatment Time**

Employees may be allowed time off with pay for short periods to obtain medical treatment authorized by Workers' Compensation relating to their occupational injury / illness. (Reference: County Code Section 6.20.070 G) A maximum of four hours per week on County time may be allowed for such treatment provided the following conditions are met:

- a. Less than six weeks have elapsed from the date of injury, and the employee has continued to receive medical treatment without change of medical provider,

or

- b Human Resources verifies either in writing, by sending the Medical Treatment Authorization, that the employee is authorized by the Third Party Claims Administrator to receive treatment from the medical provider.

and

- c Certification of Treatment for Occupational Illness or Injury, is completed by the medical provider and verifies treatment.

and

- d The employee remains at work a minimum of four hours during the work shift in which medical treatment time is requested.

3. Additional time off may be allowed in special circumstances where the employee's physician verifies the need for more frequent treatment.

Verification for more frequent treatment may be made in the following ways:

- a By the treating physician to the Division Chief either orally, or in writing on physicians' letterhead.
- b By the Division Chief once the TPC Administrator has authorized more frequent treatment.

Employees are responsible for and shall be encouraged by the Supervisor / Division Chief to arrange their medical appointments at a time which requires no, or as little, time lost from work as possible.

Whenever possible, appointments shall be arranged at the beginning or end of the regular work day or for a non-working day. The Division Chief / Supervisor may request, at his/her discretion, verification of the reason an appointment cannot be scheduled at the beginning or end of the day.

Where the above conditions for absence with pay for medical treatment are not met, an employee may request, and the Division Chief may grant, regular sick time off. When there is any uncertainty or questions regarding an employee's eligibility to receive County time off for medical treatment, the Division Chief / Supervisor shall contact Human Resources for clarification and verification.

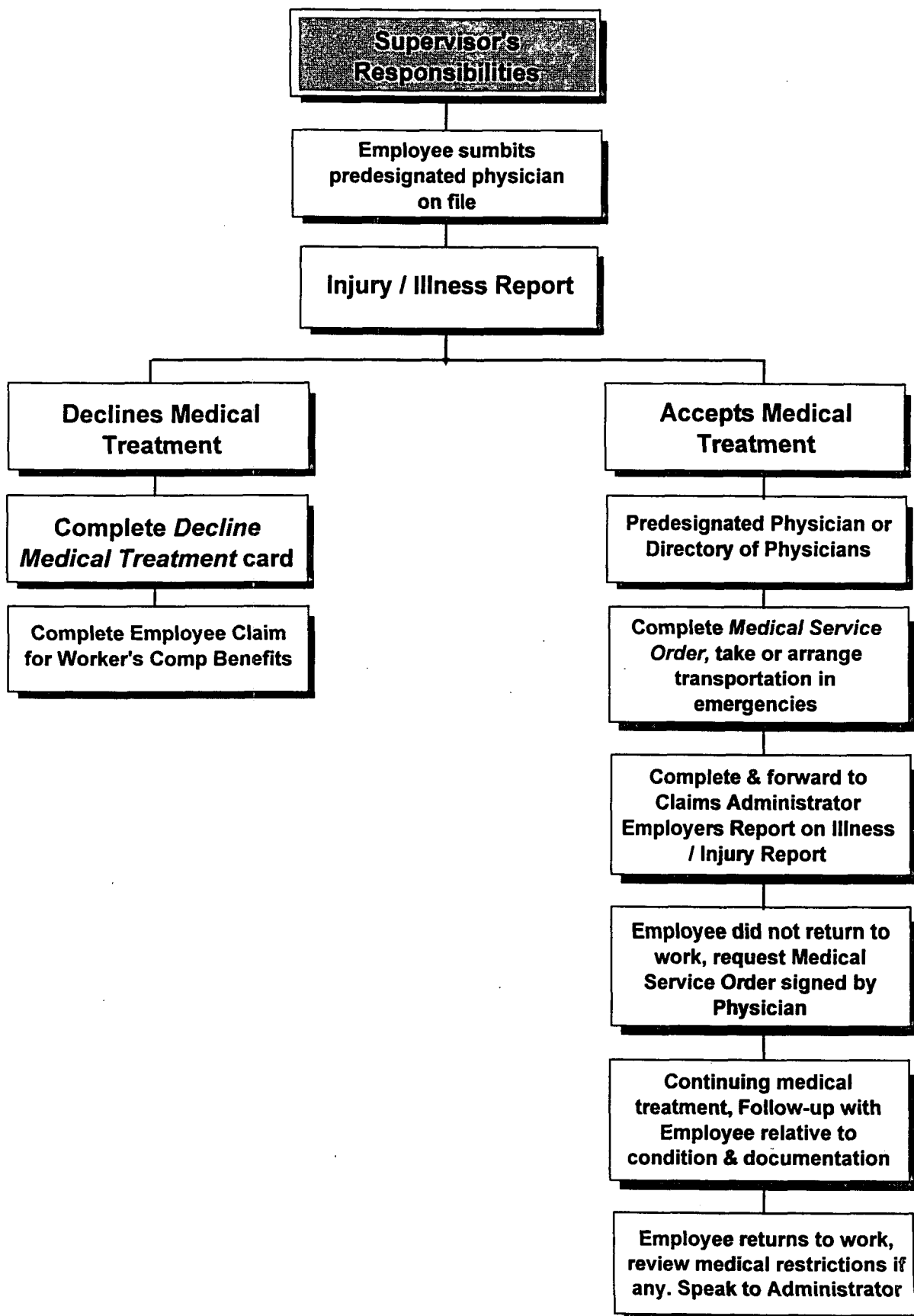
**E. Medical Treatment Declined/Waived**

If the employee declines medical treatment, the Employee's Statement Waiver of Medical Treatment form (Appendix 6) must be completed by the supervisor and signed by the employee. The supervisor also completes the Employer's

Report of Occupational Injury or Illness form, makes a copy of each for the Divisional file and submits it to the return to work coordinator (Division Chief) or the Court Administrator. The return to work coordinator makes copies of the two forms for the employee's industrial injury folder and submits the form to the Human Resources located in the Downey Courthouse.

The Employee's Statement Waiver of Medical Treatment form is not a waiver of any of the employee's rights under workers' compensation laws in the event of future medical treatment is required.

## SUPERVISOR'S RESPONSIBILITY





## **CHAPTER 4: GENERAL INSTRUCTIONS .....**

### **A. THE SUPERVISOR SHOULD KNOW THE MEDICAL FACILITY IN THE AREA OF EMPLOYMENT.**

Study the directory of medical facilities in your area and become familiar to their locations where you and your subordinates work.

### **B. TO REPORT AN EMERGENCY**

When a person stops breathing death may occur in 4 to 6 minutes. When a person is bleeding badly, unless the bleeding is stopped within a few minutes, the victim may die. In an emergency, seconds and minutes can make the difference between life and death. Decisive, quick and proper action by you can save a life!

When reporting an emergency:

1. If the injured or ill person is not breathing, help them first, then call for help - or get someone else to call. Call 9 + 911 at once.
2. If the injured or ill person is breathing, call 9 + 911 at once or follow your department's instructions.
3. When you call 911:
  - Give the telephone number from which you are calling.
  - Give the address and any special description of how to get to the victim.
  - Describe the victim's condition as best as you can . . . . . burned, bleeding, broken bones, . . . . . etc.
  - Give your name.

Do not hang up! Let emergency persons end the conversation. They may have questions to ask you or special information to give you about what you can do until help arrives.



4. Inform and request assistance from the Sheriff's Department in your facility because they can guide emergency help providers into your facility.

5. Inform Administration within your facility.

**C. IN EMERGENCIES, GET AN AMBULANCE.**

In serious injury cases an ambulance should be used. Private or County vehicles should be used to transport a seriously injured employee only when an ambulance is not readily available or is unobtainable.

**D. IN EMERGENCIES, USE THE NEAREST MEDICAL FACILITY AVAILABLE**

In cases of serious injury, when a listed county-approved medical facility is not nearby, the nearest physician or facility may be used. The exception however, should be necessary only in rare instances. (Except in bona fide emergencies, the County will not assume financial responsibility for medical treatment obtained from doctors or facilities other than those listed.

**E. USE A MEDICAL SERVICE ORDER WHEN AN EMPLOYEE OBTAINS TREATMENT**

When a supervisor refers an injured employee for treatment, he /she should give him/her a County Medical Service Card indicating the name and address of the physician or medical facility from which treatment is to be obtained if circumstances permit, the employee may be given a choice of facilities or physicians most convenient to either his work area or home location. CAUTION: After initial treatment, any change of physicians must be approved by the Third Party Claims Administrator.

**F. REPORTING OCCUPATIONAL INJURIES/ILLNESSES**

Following an injury, the supervisor should instruct the employee to return the Medical Service Order and Employee's Claim for Worker's Compensation Benefits form promptly to him/her, either personally or by mail. The supervisor will complete the Employer's Report of Occupational Injury or Illness form. (See instructions for processing Employer's Report of Occupational Injury or Illness form. (Appendix G)

and an example Employer's Report of Occupational Injury or Illness (Appendix 8)

The supervisor will provide the employee with the Employee's Claim for Worker's Benefits form. The employee should fill in the top portion of the form and return it to the supervisor the same day. If the employee's injury is such that it is not practical for him/her to complete the claim form the same day, the supervisor will mail the form to the employee's home address with an explanation cover letter requesting completion. The supervisor should then complete the "Proof of service by Mail Form". (Appendix 18)

Within one working day, the supervisor should complete the Employee's Claim for Workers' Compensation Benefits, make a copy for the divisional file and submit the form to the Division Chief/Court Administrator. The Division Chief/ Court Administrator will send a copy to APMC Human Resources located in the Downey Courthouse. They will also mail and fax a copy of the Employee's Claim for Workers' Compensation Benefits within 48 hours from the date of event to the Claims Administrator. A copy should be placed in the employee's industrial injury folder.

Within two days, the supervisor should complete the Employee's Report of Occupational Injury or Illness, make a copy for the divisional file and submit the form to the Division Chief / Court Administrator.

The return to work coordinator (Division Chief or the Court Administrator) will fax and mail a copy of the Employee's Report of Occupational Injury within five (5) days from the date of event to the Claims Administrator. A copy should be placed in the employee's industrial injury file. The claims administrator will send copies to the Department of Industrial Relations, Division of Labor Statistics and Research, P. O. Box 5971, San Francisco, CA 94101.

The Medical Services Order Card or the Employee's Statement Declining Medical Treatment Card and any medical statements are forwarded with the occupational injury/illness forms to the Division Chief. The last line of the Employee's Report of Occupational Injury or Illness should not be filled out. This is done by the Division Chief or Court Administrator after verification of pertinent information completed

on the Employee's Report of Occupational Injury or Illness. After ensuring that the report is typed and correctly completed, the Division Chief will initial it in the upper right-hand corner and forward it and all Appendixs to the ACMC Human Resources division located in the Downey Courthouse, ATTENTION: HUMAN RESOURCES.

ACMC Human Resources and the Division Chief will enter industrial injury or illness on the courts' log. (Appendix J)

The Division Chief and ACMC Human Resources also enters industrial injury/illness, except for first aid treatments, on Cal/OSHA Log. (Appendix 17) The Division Chief will send a copy of the last page of the Cal/OSHA Log, excluding names and types of injuries, to the Division Chiefs or the Court Administrator to post on bulletin board where employees can review between February 1 to March 1 of every year.

The Division Chief will retain a copy of the Employer's Report of Occupational Injury or Illness, Employee's Claim for Worker's Compensation Benefits form, medical cards, hospital and physicians bills and medical slips in the employee's industrial injury folder. Originals of above forms will be sent to the Third Party Claims Administrator.

The Division Chief will make an industrial injury folder for the employee and place all documents on the left side of the folder. Place progress for notes on the right side.

When an employee transfers out of your jurisdiction to another court, the Division Chief will mail industrial injury file to the new location.

1. SUPERVISOR MUST REPORT ALL INJURIES TO THE DEPARTMENT HEAD OR THE COURT ADMINISTRATION.

Controls must be established to ensure that all work-incurred injuries are immediately reported. It is State law. Injured employees should be requested to keep their immediate supervisor informed of their medical and recovery status.

The Board of Supervisors adopted a policy which guarantees that:

- a. Workers' Compensation laws will be liberally construed in favor of the employee: No employee will be discharged or otherwise discriminated against because he reports any work-related injury or otherwise applies for Workers' Compensation benefits.
- b. An injured employee will be provided with the finest of physician and hospitals available and will be provided with full information regarding his rights and benefits under applicable laws and County ordinances. These benefits include medical treatment and hospitalization necessary to cure and relieve the effects of industrial injury, temporary disability compensation while disabled from working, and permanent disability compensation whenever there continues to be any permanent disability following medical treatment.

In addition to the temporary disability prescribed by law, the County will provide an additional benefit to its permanent employees who are injured. It will make up the difference between the legally prescribed temporary disability benefit and 70% of the employee's regular salary during the period he or she is entitled to the temporary disability benefit, but not to exceed one year or the number of days equal to the period of the employee's continuous service immediately prior to such injury, whichever is less.

## 2. INFORMATION RELATED TO OCCUPATIONAL INJURIES / ILLNESSES

Employer should be informed that their absence due to an occupational injury or illness is governed by the County's Attendance Policy, and all absences must be verified in writing by a Physician's Statement.

An employee should never be returned to work without a physician's statement. If the physician statement includes work restrictions, we should not return the employee unless there is a

time limitation on the **restrictions** and the Division/Department can temporally accommodate those restrictions.

If an employee submits a return to work release which includes work restrictions, the **medical slip** should specify the restriction and how long the work restriction will last. The Division Chief should be consulted **before** the employee is allowed to return to work. If possible, the employee should provide a medical slip before they are due to **return**. When an employee returns to work, the supervisor should **immediately** notify the Division Chief. The employee must not **return** to his work location until approval by the Division Chief has **been** made.

Whether or not an **employee** with restrictions will be allowed to return to work will be **decided** by the Division Chief or the Court Administrator or ACMC Human Resources.

Employees who are **absent** for a period of 4 days or more should contact the Division Chief with information regarding their status, anticipated return to **work** date, and should keep their supervisor advised of their status **on a weekly basis**.

#### **G. REFERRING EMPLOYEE FOR INITIAL MEDICAL TREATMENT**

The most important action to be **taken** by the supervisor after an injury or illness is to refer the employee for medical treatment. This referral is made by the supervisor.

The supervisor must give the **employee** a Medical Service Order Form (Appendix 19) and an Employee's Claim for Worker's Compensation Benefits Form (Appendix 7) to **complete**. The supervisor will prepare the top part of the Medical Service Order card and give it to the employee.

The employee should take the **Medical Service Order Form** to either a physician in the Directory of Physicians and Medical Facilities or to the physician **predesignated** by the employee for industrial injury.

Employee's can predesignate their own physician by completing the Industrial Injury Designation of Personal Physician prior to date of injury. (Appendix 18). When the return to work coordinator (Division Chief, or Court Administrator) is informed of an injury or illness, check the employee's file to see if a predesignated physician has been named. Send the employee to their physician if one has been predesignated.

The employee must return the completed Medical Service Order and Employee's Claim for Worker's Compensation Benefit form promptly to his/her supervisor after having been seen by the treating physician, either personally or by mail.

In cases of serious illness or injury requiring emergency medical treatment (suspected heart attack, loss of consciousness, etc.) paramedics or an ambulance should be called and the injured or ill employee should be taken to the nearest medical facility. Private or county vehicles should not be used to transport seriously injured or ill employees. A Medical Service Order is not required in emergencies.

In the event of serious illness/injury or death, the supervisor should telephone the information required on the Employer's Report of Occupational Injury or Illness Form (Appendix 8), to the return to work coordinator (Division Chief or Court Administrator)

The supervisor should send either a completed medical Service Order card or Statement Waiving Medical Treatment card with a completed Employee's Claim for Worker's Compensation Benefits and Employer's Report of Occupational Injury or Illness to the return to work coordinator.

The employee is usually able to return to work the following day; however, he/she may be scheduled for follow-up medical treatment. The doctor should fill out a medical statement each time the employee is examined and it should be presented to the supervisor upon the employee's return to work.

## **H. REQUEST FOR LEAVE OF ABSENCE**

Refer to Leave of Absence Policy and Procedure for explanation of the different types of Leave of Absences. If an employee is absent from work 5 or more working days, a Request for Leave of Absence form must be filled out. The following procedure are required:

- Employee submits Leave of Absence form to their supervisor.
- Supervisor reviews and submits approved Leave of Absence form to the Division Chief.
- Division Chief approves or denies request and submits approved Leave of Absence with pay to Assistant Court Administrator
- Assistant Court Administrator submits approved Leave of Absence form to Court Administrator.
- Court Administrator reviews approved Leave of Absence form and returns it to the Return to Work Coordinator.
- The Return to Work Coordinator will respond in writing to employee or to the division supervisor if appropriate.

## **I. EMPLOYEE UNABLE TO RETURN TO WORK FROM OCCUPATIONAL INJURY OR ILLNESS (VOCATIONAL REHABILITATION)**

If the departmental efforts (reassignment, voluntary demotion with salary supplementation y-rate) are not successful in placing an employee with industrial work restrictions, the Rehabilitation Services Section of Worker's Compensation will contact the return to work coordinator (Division Chief or Court Administrator) for assistance.

If the Rehabilitation Services Section of Worker's Compensation is unable to place the employee, retraining and or other professional assistance may be provided through vocational rehabilitation by a contractor. If an employee has a permanent medical restriction or is totally disabled due to an occupational injury or illness, he/she may apply for a disability retirement. The Return to work Coordinator may give an employee a Vocational Rehabilitation pamphlet for review.

If after a Countrywide employment search, the Return to work Coordinator is unable to place the employee, a request for medical release (With accompanying support documentation) should be submitted to Disability Benefits Division. As agreed

vocational evaluator will work with the employee to develop a plan for employment outside the County.



## **CHAPTER 5: THIRD PARTY CLAIMS ADMINISTRATOR .....**

After submitting an employee's forms pertaining to an occupational injury or illness to the 3rd party claims administrator. The 3rd party claims administrator may request additional information.

### **I. Procedures**

Prior to an employee's case being deemed compensable, the 3rd party claims administrator may request the following information. The form will request either of the following:

- a copy of the injured's personnel file and the unit supervisor's personnel desk file.
  - a job analysis. (which must be submitted within 30 days)
  - a copy of the claimants time card
- A. Once the investigation is completed and deemed compensable, 3rd party claims administrator will submit DWC Form 500-F to the Division Chief. The Division Chief will submit a copy of this form to the timekeeper for processing.
- B. If the claim is denied, Form (Appendix 2) is sent to the Division Chief.
- C. The 3rd party Claims Administrator may request the verification of our records for the employee's first, second, and additional years of salary continuation benefits. The following information is requested for ongoing benefits:
- (1) beginning date of benefit
  - (2) rate of percentage
  - (3) regular earnings, effective date (s)

The following information is requested for after termination benefits:

- (4) rate of percentage
- (5) regular earnings, effective dates (from and through) and amount paid.

If 3rd party claims administrator requests a yearly salary verification prior to the date of injury or illness, the 3rd party claims administrator submits it to the timekeeper for completion. The 3rd party claims administrator makes a copy of any completion

## **II. INVESTIGATING OCCUPATIONAL INJURIES/INJURIES**

All accidents should be investigated by the supervisor and/or Division Chief to determine the primary cause. This investigation should be performed by a person familiar with the duties of the employee. The following guidelines are used when investigating:

- Interview witnesses individually.
- Reassure each witness that the purpose of your investigation is fact-finding only.
- Be objective.
- Record all information and verify pertinent facts.
- Provide written results of the investigation of the Divisions Safety Coordinator for corrective action,

## SITUATIONS THAT MAY WARRANT INVESTIGATION

### SOLICITATION INDICATORS

Several employees from same employer have similar injuries, use same doctor and/or attorneys.

First notice of claim from attorney or medical clinic

Employee's medical clinic provides First Report of Injury and lists attorney's name at bottom of form.

### AOE/COE INDICATORS

Employer planning or in process of a plant shutdown

Employer was cutting back hours or laying people off.

Employee Terminated.

Claimant was the subject of an immigration raid.

Employee has a history of personal injury and/or Workers' Comp claims.

Employer notified employee of his/her poor performance, etc.

Index Bureau inquiry reports many prior claims.

Employer was not notified by employee when injury occurred.

Fellow employees state injury is not valid, no one was aware of injury.  
Employee is a relatively new hire.

Claimant was unable to work another job, but continued to receive medical treatment for work related injury.

### MED/MED-LEGAL INDICATORS

Multiple med-legal referrals as a clinic practice regardless of injury types.

"Skin and contents" type of allegation-often a post-termination claim.

Medical reports appear to be photocopied with the same information typed in (employer, employer's address, injury description).

The same doctor(s) and attorney repeatedly involved together on claims of questionable merit.

Employee visits doctor's office frequently and always receives same type of treatment.

Reports from doctor on various Workers' Comp claims read almost identical.

Medical bills indicate treatment on weekend or doctor's usual day off.

Medical bills include extensive testing that would not be performed by a family doctor for the injury alleged.

Injuries are of a subjective nature (e.g., stress, headaches, etc.) and there are no credible, objective findings.

Such ailments persist more than two weeks

Any single indicator does not necessarily establish fraudulent activities; however, their presence suggest further investigation.

TABLE NO. III

### III. RECURRING INJURIES / ILLNESSES

If an employee complains of physical difficulties from a previously reported injury or illness, the employee should contact the Division Chief for consultation.

If an employee's case has been deemed compensable by the third party claims administrator, he/she has the authority to see a physician and not lose any benefits. All medical and hospital bills are sent to the third party claims administrator.

If an employee's case was denied by the third party claims administrator, he/she must see their own physician on their own time and pay for their own medical and hospital cost.

### IV. SUBJECTIVE ILLNESS

Any subjective illness which an employee claims is the result of his work or working conditions must be reported on the Employer's Report of Occupational Illness or Injury.

The illnesses include:

- a) Stress and Strain - employee claims to be suffering psychological stress and strain as a result of the job.
- b) Cumulative trauma - employee claims an ongoing illness (i.e., heart disease, hypertension) is the result of the job.
- c) Other illnesses - employee claims to be suffering subjective complaints such as headache, upset stomach, head cold, believed due to the air conditioning, smoke in air, etc.

Subjective illness cannot be assumed to be work related; this determination must be made by the 3rd party Claims Administrator. Medical Service Order 76M119F, shall not be issued to an employee for a subjective illness.

## **V. REPORTING VEHICLE ACCIDENTS**

Vehicle accidents involving employee using county vehicles are to be investigated by the supervisor. The following forms must be submitted to the Division Chief or the Court Administrator if the employee is injured.

- Employee's Claim for Worker's Compensation Benefits form
- Employer's Report of Occupational Injury or Illness form
- Report of Vehicle Accident form

If the employee is not injured, the supervisor completes an Incident form and submits it to the Court Administrator.

Forms are completed by the supervisor and submitted to the Division Chief immediately. The supervisor and the Division Chief makes copies for their divisional and employee's industrial injury folders. The Division Chief submits completed forms to the 3rd party claims administrator.

## **VI. LONG TERM DISABILITIES - NON-MEGA FLEX EMPLOYEES**

When an employee is on a long term, (6 months +) illness, injury, or non-related industrial medical leave the return to work coordinator (Division Chief or Court Administrator) will mail a cover letter, Application for Long Term Disability and Long Term Disability brochure to the employee.

No benefits will be paid to the employee if the application is not made within one-year from the first day of absence due to the claimed disability.

The employee returns part I of the Application for long term disability to return to work coordinator (Division Chief or Court Administrator). The return to work coordinator submits part I of the application to the Long-Term Disability Section of the Chief Administrative Office. Part II is completed by the attending physician and returned to the County of Los

Angeles, CAO's Office, Long Term Disability Section, 14365 Goodrich Blvd., Commerce, CA 90022.

The Long Term Disability Section will contact the employee to either approve or deny the application. The Long Term Disability Section may contact the return to work coordinator for additional information pertaining to the employee's claim for Long Term Disability.

## **VII. SURVIVORS BENEFIT PLAN**

The long term disability and survivor benefit plan may pay benefits where death or disability resulting from non-industrial causes as well as those die to on-the-job illnesses or injuries.

This plan provides disability benefits to employees who are general members of the County's retirement plans should they become totally disabled. It also provides benefits to a qualified surviving spouse or child on the death of an employee who would have been eligible for long-term disability benefits.

Any employee who is a member of Retirement Plan A, B, C, or D and who was absent from work for 30 or more consecutive days between 4/1/85 and 6/30/85 is not covered under this Plan unless he/she returned to work for 90 consecutive days following 7/1/85 or became disabled or died on or after 7/1/85 due to a cause unrelated to the cause of his/her prior disability.

To be eligible for these benefits, an employee must meet the following criteria:

1. Be a general member of Retirement Plan A, B, C, D, or E, and
2. Be totally disabled, and either
3. Have completed 5 or more years of continuous County service, or
4. Be totally disabled as a direct consequence and result of an injury or disease which arose out of and in the course of the performance of his/her assigned duties.

## **VIII. BENEFITS PROVIDED UNDER VOCATIONAL REHABILITATION**

Maintenance Allowance

Plans

Mileage

Clothing Equipment

Babysitting





**Rehabilitation  
Time  
Notice Requirements  
(Labor Code Section 4636 a, d: 4637 a, b and A.D.  
Rule 10123 & Penalty Section 10108)**

**\$500.00 Penalty Each Failure**

All required notice letters shall be sent to employee on a timely basis by the Third Party Claims Administrator in the form and manner prescribed by the Court Administrator with a copy to Human Resources Department located at the Downey Courts. The following notices are timely when sent within the following periods:

<b>TIME</b> (in days)	<b>TYPE OF NOTICE</b>
90 + 10	(1) The 90-day QRR assignment notice is to be sent within 10 days subsequent to 90 days of aggregate total disability.
10	(2) The notice of Potential Eligibility is to be sent within 10 days of knowledge of employee's medical eligibility for vocational rehabilitation services.
45-70	(3) The Remainder Notice is to be sent not earlier than 45 days nor later than 70 days after the employee's receipt of the Notice of Potential Eligibility.
10	(4) The Notice of Non-Eligibility is to be sent within 10 days of knowledge of non-eligibility for Vocational Rehabilitation Services.
10	(5) The Notice of Treating Doctors Final Report is to be sent within 10 days of the receipt of the Doctor's Report.

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**TABLE NO. IV**

10 (6) The Notice of Interruption is to be sent within 10 days of the agreement to interrupt.

15 (7) The Notice of Intent to Withhold Maintenance Allowance is to be sent at least 15 days prior to withholding rehabilitation benefits.

10 (8) Notice of Potential Refund to Employer is to be sent by the insurer to the employer within 10 days of the approval of a plan by the Rehabilitation Unit.

# Lost Time Claim

Return to Work

Full recovery - No  
permanent disability

File Closure

CONTINUED DISABILITY

LITIGATION

Pursue Return to Work or  
Determine Qualified Injury

Ascertain Level of  
Permanent Disability

Possible Defense Attorney  
Referral

Medical / Legal  
Evaluation

Possible Trial

Finding &  
Award Issued

Monitor Future  
Medical

File Closure

Possible  
Agreed  
Medical

RESOLUTION OF CLAIM  
STIPULATED AWARD OR  
COMPROMISE & RELEASE

Monitor Future  
Medical

File Closure

NON-LITIGATION

Pursue Return to Work or  
Determine Qualified Injury

Ascertain Level of  
Permanent Disability

Qualified Medical Examiner  
(QME)

Resolution of Claim  
Stipulation Award  
Compromise & Release

Monitor Future  
Claim

File Closure



## **CHAPTER 6: HOW TO CODE TIME OFF FOR OCCUPATIONAL INJURY/ILLNESS**

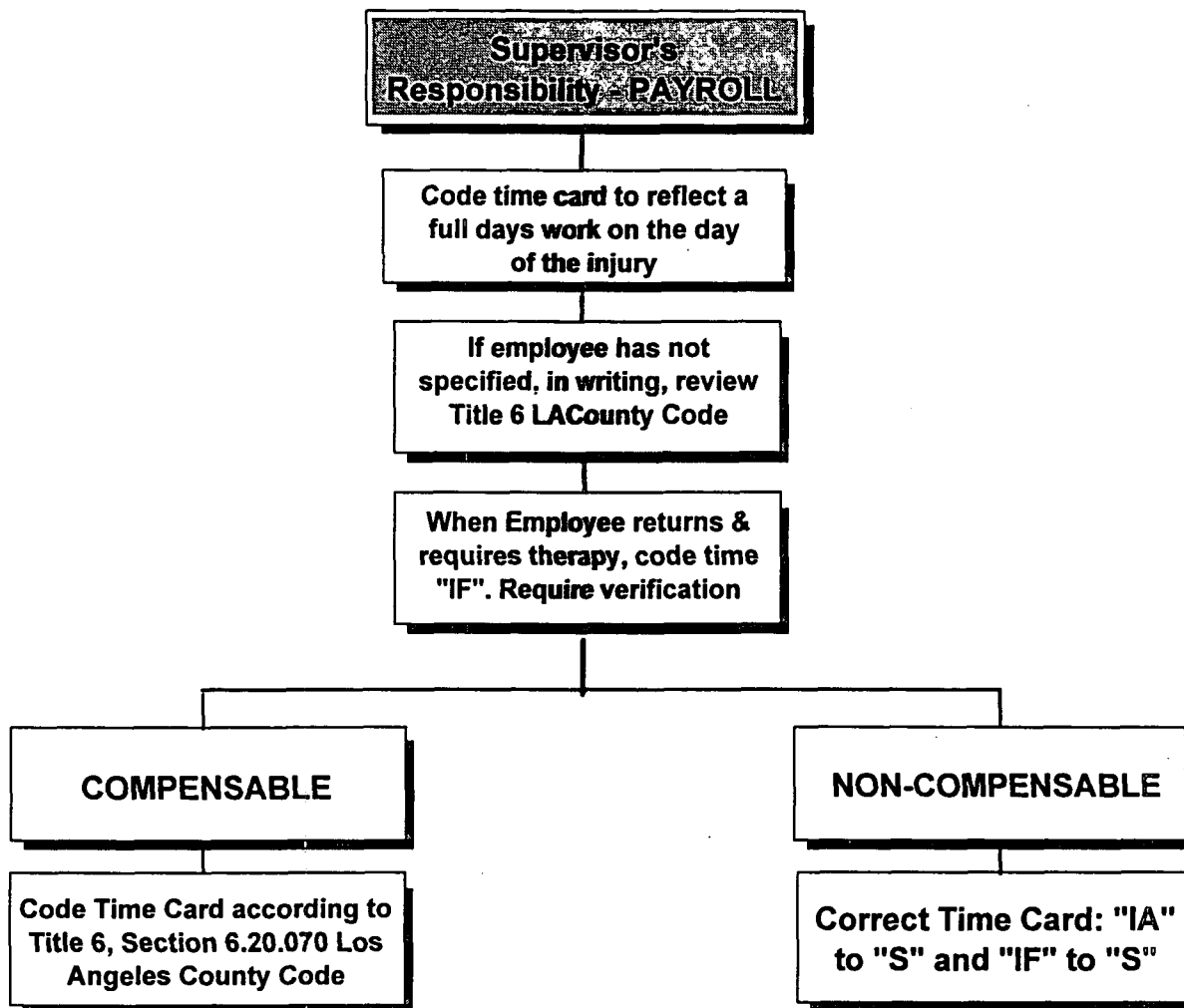
When an employee is compelled to be absent as a result of an occupational injury or illness, the time off shall be reported for the first day as "I", any days after the first day shall be reported as "SI" (Sick Industrial Pending). Sick benefits or other accumulated benefits will be used until information is received from the 3rd Party Claims Administrator as to whether or not the claim is compensable. Since compensation is paid at the rate of 70% of gross salary. Timekeeper will restore to the employee 70% of the 100% time used and all 65% and 50% sick time used minus the first three days of time lost unless the employee is off work more than fourteen (14) days. If an employee is absent more than fourteen days, the first three (3) days of lost time is also restored.

**NOTE:** Megaflex employees do not receive the 70% salary continuation (see section V, Page 36)

Weekly compensation rate is set by State law and determined by a set percentage of an employee's average weekly earnings prior to injury and the statutory minimum and maximum weekly rates in effect on the date of the injury. The 70% compensation payments may not exceed an employee's length of service or 1 year whichever comes first. If the empties injuries persist, they will receive the minimum benefits evaluated by State law.

If an employee's case has been compensable by the third party claims administrator, and if he/she requires follow-up treatment / therapy, they may be allowed up to 4 hours per follow-up visit. This time will be reported as "IT" (Industrial Accident Treatment/Therapy). Then "IT" time is authorized, it will be verified in writing by the attending physician or therapist. The original of all follow-up treatment slips must accompany the time sheet to the timekeeper. The supervisor can request the employee to schedule appointments for treatment at a time that is most convenient for the Division (early a.m. or late p.m.) depending on location in relation to employee's home or work place. Questions regarding scheduled treatment or timecard coding (including the use of the "Z" Code), should be directed to the Division Chief.

**SUPERVISOR'S PAYROLL RESPONSIBILITY**





7

## CHAPTER 7: RECORDKEEPING OCCUPATIONAL SAFETY AND HEALTH ACT

The Record-keeping requirements of the Occupational Safety and Health Act of 1970 apply to private sector employers in all States , the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Trust Territories of the Pacific Islands.

### 1. Employers who must keep OSHA records.

Employers including the Courts, with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name by the appropriate Standard Industrial Classification (SIC) code:

*Agriculture, forestry, and fishing*  
*Oil and gas extraction*  
*Construction*  
*Manufacturing*  
*Transportation and public utilities*  
*Wholesale trade*  
*Building materials and garden supplies*  
*General Merchandise and food stores*  
*Hotel and other lodging places*  
*Repair services*  
*Amusement and recreation services*  
*Health services.*

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

### 2. Employers who infrequently must keep OSHA records

- a All employers with no more than 10-full- or part-time employees at any one time in the previous calendar year.

Even though recordkeeping requirements are reduced, they must comply with OSHA standards display the OSHA poster, and



report to OSHA within 48 hours any accident which results in one or more fatalities or the hospitalization of five or more employees. Also, some State safety and health laws may require regularly exempt employers to keep injury and illness records, and some States have more stringent catastrophic reporting requirements.

### **3. Employers and individuals who need not keep OSHA records**

The following employers and individuals do not have to keep OSHA injury and illness records:

- Self-employed individuals;
- Partners with no employees;
- Employers of domestic workers in the employers' private residence for the purposes of housekeeping or child care, or both; and

Employers engaged in religious activities concerning the conduct of religious services or rites. Employees engaged in such activities include clergy, choir members, organist and other musicians, ushers, and the like. However, records of injuries and illnesses occurring to employees while performing secular activities must be kept. Recordkeeping is also required for employees of private hospitals and certain commercial establishments owned or operated by religious organizations.

State and local government agencies are usually exempt from OSHA recordkeeping. However, in certain States, agencies of State and local governments are required to keep injury and illness records in accordance with State regulations.

### **4. Employers subject to other Federal safety and health regulations.**

Employers subject to injury and illness recordkeeping requirements of other Federal safety and health regulations are not exempt from OSHA recordkeeping. However, records used to comply with other Federal recordkeeping obligations may also be used to satisfy the OSHA recordkeeping requirements. The forms used must be equivalent to the log and summary and the supplemental record.

## **5. OSHA Recordkeeping Forms**

Only two forms are used for OSHA recordkeeping. One form, the OSHA No. 200, serves as both the Log of Occupational Injuries and Illnesses, on which the occurrence and extent of cases recorded during the year; and as the Summary of Occupational Injuries and Illness, which is used to summarize the log at the end of the year to satisfy employer posting obligations. The other form, the Supplemental Record of Occupational Information, provides information on each of the cases that have been recorded on the log.

## **6. The Log and Summary of Occupational Injuries and Illnesses OSHA No. 200**

The log is used for recording and classifying occupational injuries and illnesses, and for noting the extent of each case. The log shows when the occupational injury or illness occurred, to whom, the regular job of the injured or ill person at the time of the injury or illness exposure, the department in which the person was employed, the kind of injury or illness, how much time was lost, whether the case resulted in a fatality, etc. The log identifies the employee and briefly describes the injury or illness; a section covering the extent of the injuries recorded; and a section on the type and extent of illness.

## **7. The Supplementary Record of Occupational Injuries and Illnesses, OSHA No. 101**

For every injury or illness entered on the log, it is necessary to record additional information on the supplementary record, OSHA No. 101. The supplementary record describes how the accident or illness exposure occurred, lists the objects or substances involved, and indicates the nature of the injury or illness and the part (s) of the body affected.

## **8. Location, Retention, and Maintenance of Records**

### **A. Establishments**

If an employer has more than one establishment, a separate set of records must be maintained for each one.

**B. Location of records**

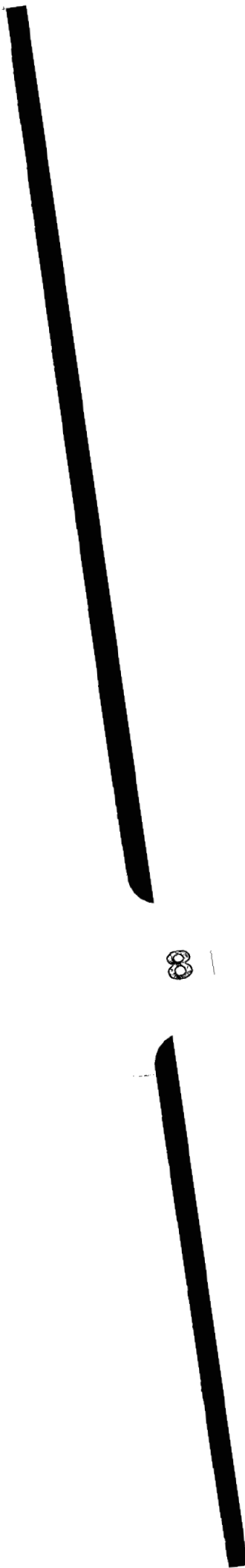
Injury and illness records (the log, OSHA No. 200, and the supplementary record, OSHA No. 101) must be kept for every physical location where operations are performed.

**C. Retention of OSHA Records**

The log and summary, OSHA No. 200, and the supplementary record, OSHA No. 101, must be retained in each establishment for 5 calendar years following the end of the year to which they relate.

**D. Maintenance of the log (OSHA No. 200)**

In addition to keeping the log on a calendar year basis, employers are required to update this form to include newly discovered cases and to reflect changes which occur in recorded cases after the end of the calendar year. Maintenance or updating the log is different from the retention of records discussed in the previous section. Although all OSHA injury and illness records must be retained, only the log must be updated by the employer. If, during the 5-year retention period, there is a change in the extent or outcome of an injury or illness which affects an entry on a previous year's log, then the first entry should be lined out and a corrected entry made on that log. Also, new entries should be made for previously unrecorded cases that are discovered or for cases that initially weren't recorded but were found to be recordable after the end of the year in which the case occurred.



## **CHAPTER 8: ACCIDENT PREVENTION AND CORRECTION OF SAFETY HAZARDS.....**

Identification and correction of safety hazards is the responsibility of each County Department Head, Hazardous work or practices shall be corrected immediately. To help prevent industrial accidents, each Department Head has the responsibility to:

1. Ensure that every new or reassigned employee is informed of the Department's rules for safe work practices and of any safety hazard peculiar to their job or work site.
2. Ensure that safety inspections are conducted at least quarterly to identify and correct unsafe conditions and work practices. Safety Inspection Checklist will serve as a record of the date of each formal inspection.
3. Review each form (Employer's Report of Occupational Injury/Illness) no later than one day after the occurrence of the accident and ensure that it is properly completed.
4. Refer emergency problems directly to the appropriate area facilities manager at the Internal Service Department.
5. Correct and identify health and safety problems as soon as possible.



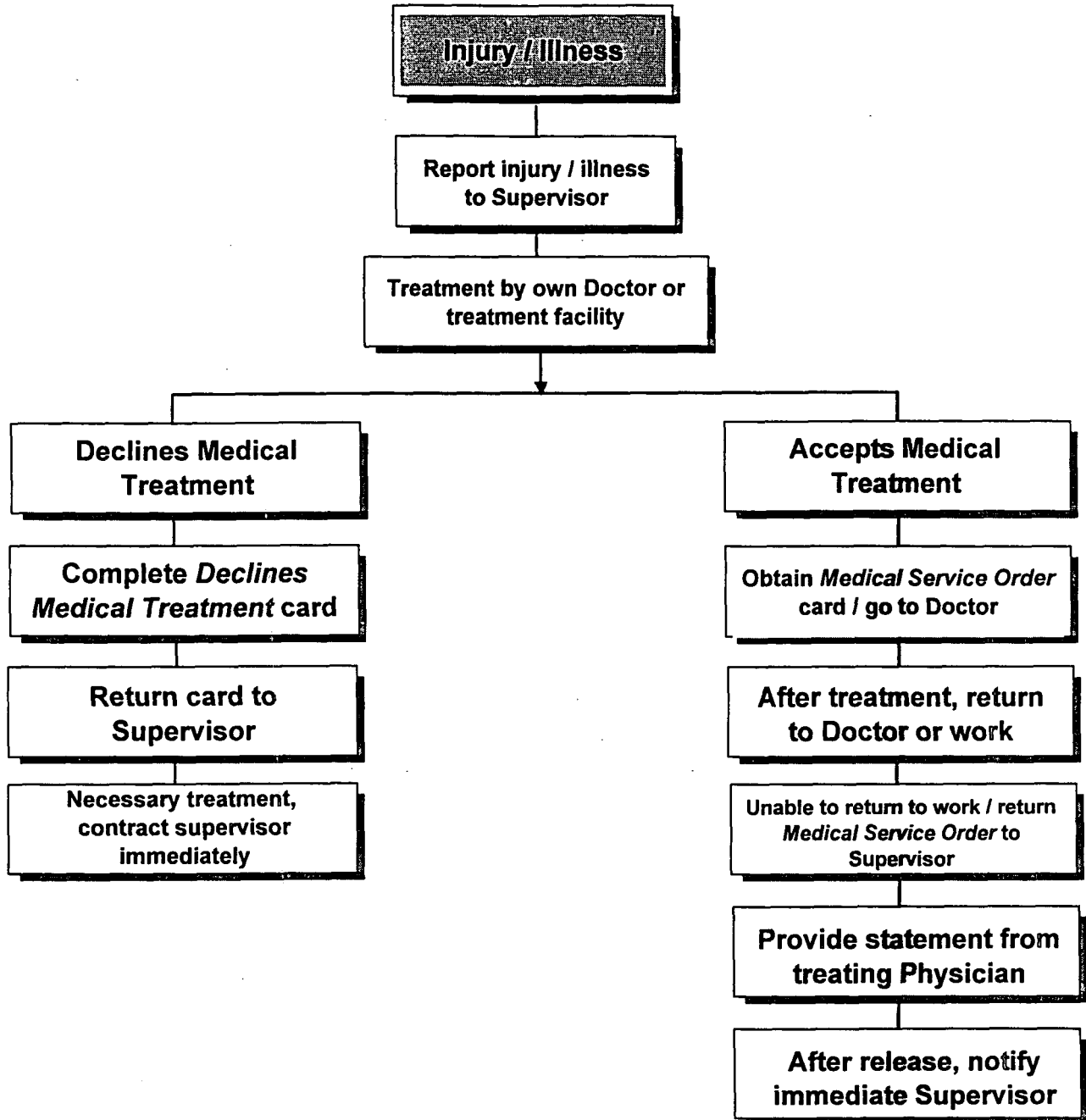
## APPENDIXES

## **APPENDIXES**

Appendix No. 01	FLOW CHART - Employee's Responsibility
Appendix No. 02	FLOW CHART - Supervisor's Responsibilities
Appendix No. 03	FLOW CHART - Lost Time
Appendix No. 04	FLOW CHART - Payroll
Appendix No. 05	ACMC - Supervisor's Report of Industrial Injury, Page 1,2
Appendix No. 06	Waiver of Medical
Appendix No. 07	DWC - Form 1 - Employee's Claim for Workers' Compensation Benefits
Appendix No. 08	Employer's Report of Occupational Injury/Illness
Appendix No. 09	Stipulation with Request for Award, Page 1,2
Appendix No. 10	Request for Treatment by personal physician
Appendix No. 11	Follow-up Medical Treatment
Appendix No. 12	SAMPLE LETTER - re: Treatment by Physician
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Appendix No. 15/16	Pie Charts - Open Cases in the Southeast Municipal Court
Appendix No. 17	Industrial Injury Claim Form Log
Appendix No. 18	Proof of Service by Mail
Appendix No. 19	Medical Service Order
Appendix No. 20	Order of Dismissal

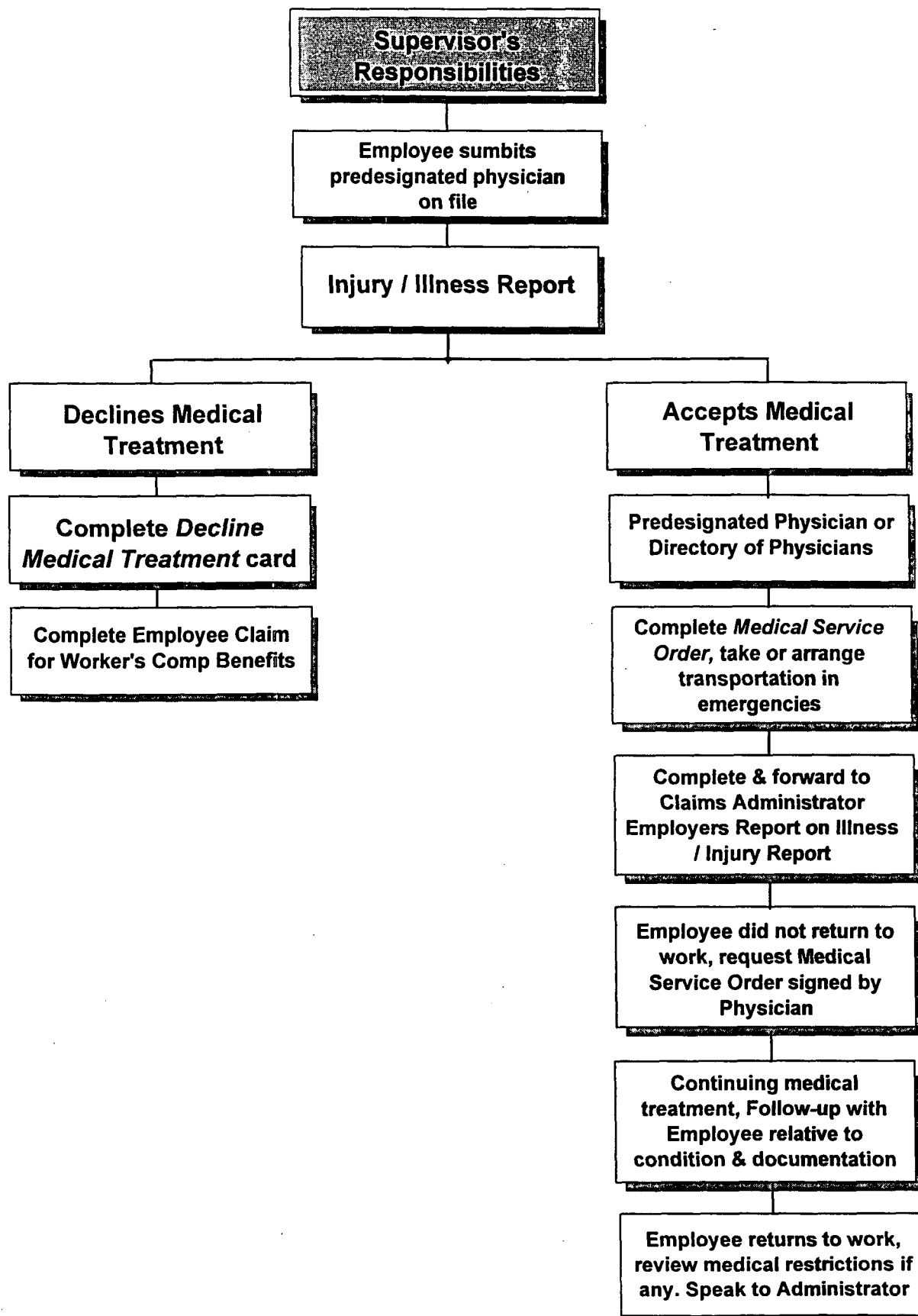


EMPLOYEE'S RESPONSIBILITY

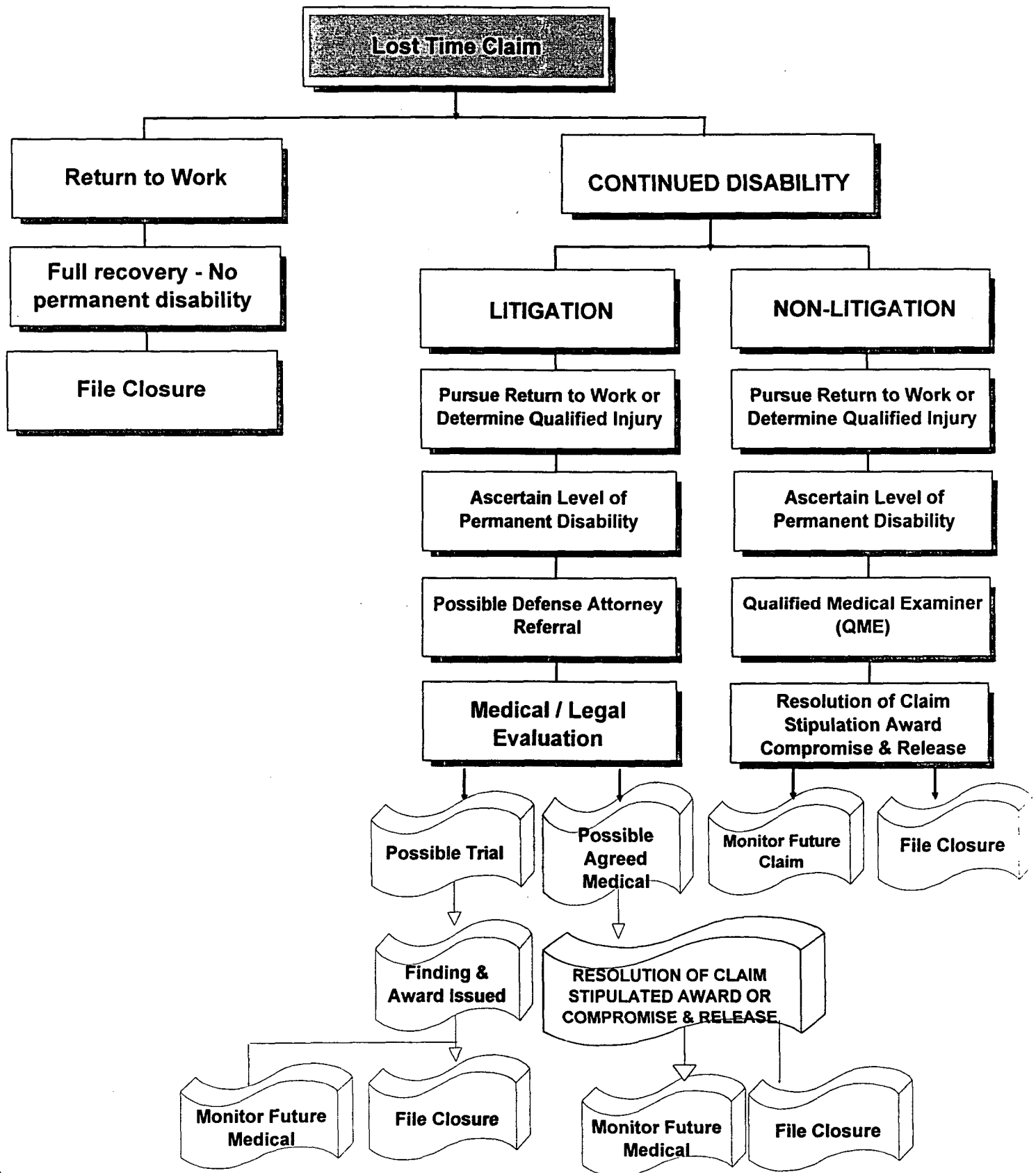


APPENDIX 1: Flow Chart  
EMPLOYEE'S RESPONSIBILITY

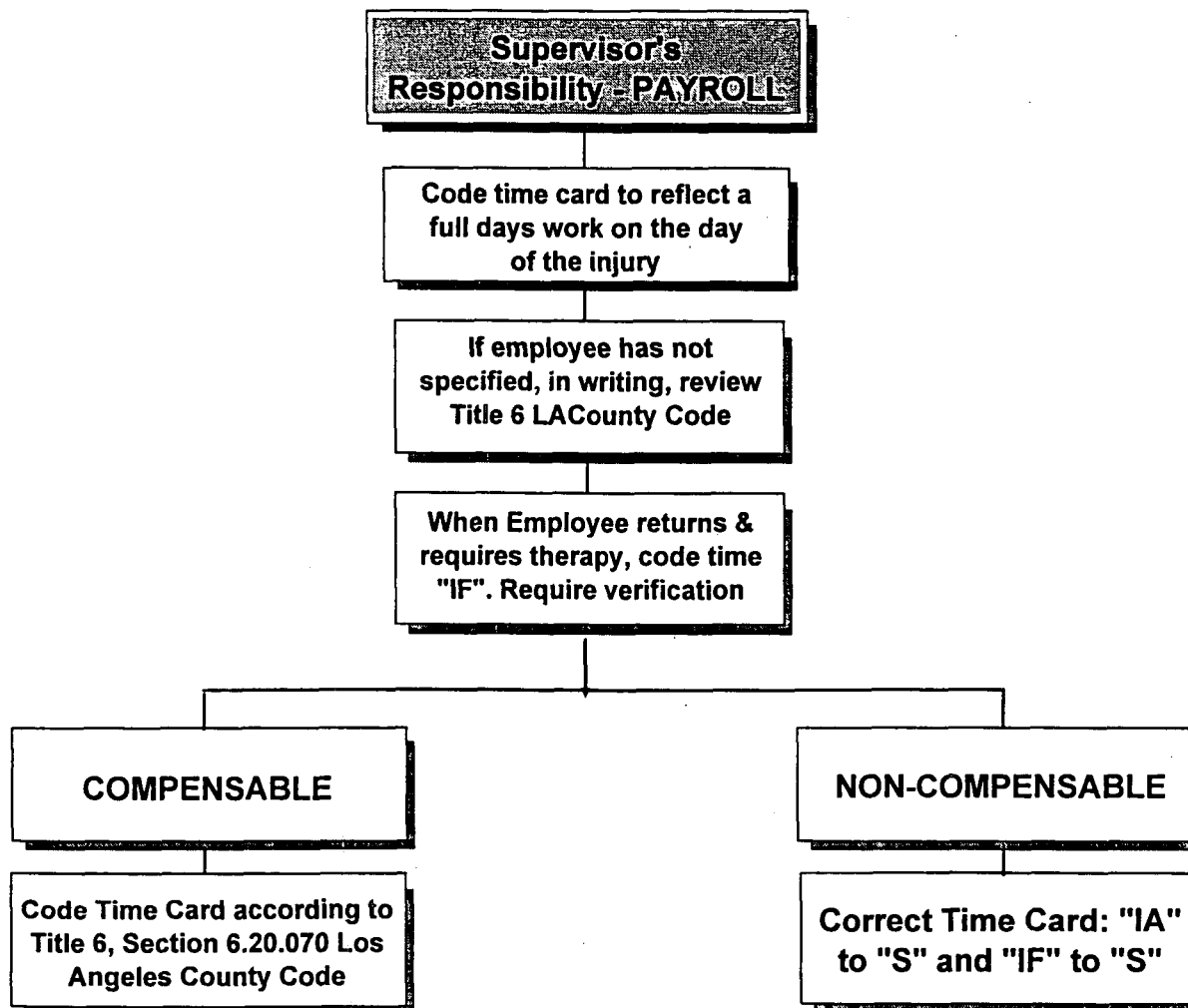
## SUPERVISOR'S RESPONSIBILITY



APPENDIX 2: Flow Chart  
SUPERVISOR'S RESPONSIBILITIES



## SUPERVISOR'S PAYROLL RESPONSIBILITY



APPENDIX 4: Flow Chart  
SUPERVISOR'S RESPONSIBILITY-PAYROLL



Administratively Consolidated Municipal Courts  
**WAIVER OF MEDICAL TREATMENT**

ADMINISTRATIVELY CONSOLIDATED MUNICIPAL COURTS

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE NO.: \_\_\_\_\_

ASSIGNED DIVISION: \_\_\_\_\_

COURT LOCATION: \_\_\_\_\_

I, \_\_\_\_\_, decline to receive medical treatment at this time for the injury incurred on this date. My reason(s) for not seeking treatment is as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I do understand that I am not waiving my right to receive treatment at a later date.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SUPERVISOR'S SIGNATURE

\_\_\_\_\_  
DATE

=====

ACMC HUMAN RESOURCES DIVISION ONLY

\_\_\_\_\_  
DATE RECEIVED

\_\_\_\_\_  
DATE FILED

\_\_\_\_\_  
BY

**APPENDIX 6: WAIVER MEDICAL TREATMENT**

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



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN TRABAJADOR

## EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

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

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 felony.

## RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de las Leyes Pertinentes llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

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

Toda aquella persona que con conocimiento 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: Empleado:

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 ocurrió 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 give the employee a copy immediately as a receipt.**

**Empleador—complete esta sección y déle inmediatamente una copia al empleado como recibo.**

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 completada al empleador. \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. \_\_\_\_\_
15. Insurance Policy Number. El número de la póliza del Seguro. \_\_\_\_\_
16. Signature of employer representative. Firma del representante del empleador. \_\_\_\_\_
17. Title. Título. \_\_\_\_\_ 15. 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**

Original (Employer's Copy)  
DWC Form 1 (Rev. 1/94) 60.5013.2140.83151 (12/95)

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

**EL FIRMA ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD**

ORIGINAL (Copia del Empleador)DWC Form 1 (Rev. 1/94)

<b>County of Los Angeles Legally Uninsured</b>		<b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		<b>LOS ANGELES COUNTY SHERIFF'S DEPARTMENT</b>									
SUPERVISOR.  SAFETY OFFICE.		1) Use this form to report all injuries and illnesses to the Safety Office. 2) Report fatal or serious injuries and illnesses immediately to the Safety Office. 3) SEND: Original and one copy to: ACMI, P.O. Box 19775, Irvine, CA 92713 4) Retain two copies, one for your files, second for establishments.								<b>EMPLOYEE NO.</b>  <b>MEGA FLEX</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>OSHA Case No.</b>  <input type="checkbox"/> Fatality	
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><b>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.</b></p> </div> <div style="width: 70%;"> <p><b>NOTICE:</b> California law requires employers to report within <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported <b>immediately</b> by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.</p> </div> </div>													
<b>EMPLOYER</b>	1. FIRM NAME <b>County of Los Angeles</b>								1A. DEPT. CODE NO.		<b>DO NOT USE THIS COLUMN</b>		
	2. MAILING ADDRESS (Number and Street, City, ZIP)								2A. PHONE NUMBER				Case No.
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, Zip)								3A. ESTABLISHMENT CODE				Ownership
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.								5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. <b>944-0503-02</b>				Industry
<b>EMPLOYEE</b>	6. TYPE OF EMPLOYER <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> School District <input type="checkbox"/> Other government — specify: _____												Occupation
	7. EMPLOYEE NAME						8. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH (mm/dd/yy)		Sex		
	10. HOME ADDRESS (Number and Street, City, Zip)								10A. PHONE NUMBER		Age		
	11. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		12. OCCUPATION (Regular job title — NO initials, abbreviations or numbers)						13. DATE OF HIRE (mm/dd/yy)		Daily hours		
	14. EMPLOYEE USUALLY WORKS hours _____ days _____ total _____ per day _____ per week _____ weekly hours _____				14A. EMPLOYMENT STATUS (check applicable status at time of injury) <input type="checkbox"/> regular full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal				14B. JOB ITEM NO.		Days per week		
<b>INJURY OR ILLNESS</b>	15. GROSS WAGES/SALARY \$ _____ per _____						16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> Yes, \$ _____ per _____ <input type="checkbox"/> No						Weekly hours
	17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)				18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.		19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.		20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		Weekly wage		
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No				22. DATE LAST WORKED (mm/dd/yy)		23. DATE RETURNED TO WORK (mm/dd/yy)		24. IF STILL OFF WORK CHECK THIS BOX <input type="checkbox"/>		County		
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No				26. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Nature of Injury		
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.												Part of body
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)						30A. COUNTY		30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		Source		
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.								32. OTHER WORKERS INJURED/ALL IN THIS EVENT? <input type="checkbox"/> Yes <input type="checkbox"/> No				Event
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.												Sec. Source
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.												Extent of Injury
	35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.												
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)										36A. PHONE NUMBER			
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)										37A. PHONE NUMBER			
COMPLETED BY (type or print).				SIGNATURE				TITLE				DATE	

**SEND REPORT IMMEDIATELY TO CLAIMS UNIT AFTER INJURY OR ILLNESS. DO NOT WAIT FOR DOCTOR'S REPORT.**

WORKERS' COMPENSATION APPEALS BOARD  
STATE OF CALIFORNIA

\_\_\_\_\_  
*Applicant*

Case No. \_\_\_\_\_

**Stipulations  
with Request  
for Award.**

\_\_\_\_\_  
*Defendants*

The parties hereto stipulate to the issuance of an Award and / or Order, based upon the following facts, and waive the requirements of Labor Code Section 5313.

1. \_\_\_\_\_ born \_\_\_\_\_ while  
employed within the State of California as \_\_\_\_\_ on \_\_\_\_\_  
by \_\_\_\_\_ whose compensation insurance carrier was  
\_\_\_\_\_ sustained injury arising out of an in the course of employment \_\_\_\_\_.

2. The injury caused temporary disability for the period \_\_\_\_\_  
through \_\_\_\_\_ for which indemnity is payable at \$ \_\_\_\_\_ per  
week, less credit for such payments previously made.

3. The injury caused permanent disability of \_\_\_\_\_%, for which indemnity is payable at \$  
\_\_\_\_\_ per week beginning \_\_\_\_\_, in the sum of \$ \_\_\_\_\_. less credit for such  
payments previously made.

An informal rating has not been previously issued.  
(Select One)

4. There is not may be for medical treatment to cure or relieve from the effects of said injury.  
(Select One)

APPENDIX 9: Stipulations with Request for Award



**WORKERS COMPENSATION APPEALS BOARD**  
STATE OF CALIFORNIA

5 Medical-legal expenses are payable by defendant as follows:

6. Applicant's attorney requested a fee of \$ \_\_\_\_\_.

7. Liens against compensation are payable as follows:

8. Other stipulations:

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Social Security Number of Applicant

\_\_\_\_\_  
Address of Employer

\_\_\_\_\_  
Address of Applicant

\_\_\_\_\_  
Address of Insurance Company

\_\_\_\_\_  
Attorney for Applicant

\_\_\_\_\_  
Attorney or Authorized Representative for Deft.

\_\_\_\_\_  
Address of Attorney for Applicant

\_\_\_\_\_  
Address of Attorney or Authorized Representative

**ADMINISTRATIVE CONSOLIDATED MUNICIPAL COURTS  
LOS ANGELES COUNTY**

**INDUSTRIAL INJURY DESIGNATION OF PERSONAL PHYSICIAN**

Under provisions of the Workers' Compensation law, you have the right to be treated by your personal physician after an industrial injury/illness if you have previously submitted written notice to your department of this choice. A personal physician is defined as your regular physician who has previously directed your medical treatment and who retains your medical records and medical history.

If you do not predesignate your personal physician, you will be referred to a doctor or medical facility listed in the "Directory of physicians and Medical Facilities for Industrial Injury". The doctors listed in the Directory have been selected by the County based on their medical competence, professional reputation, willingness to treat industrial injuroes, and their provisions of unbiased and prompt medical information. After 30 days, you may elect to choose another physician to provide care. You may at any time request one change of physician if you are not satisfied with the treatment you are receiving.

In emergencies involving serious injuries, you will be sent to the nearest emergency physician or medical facility, whether or not it is your predesignated physician or a physician or facility listed in the Directory.

Please complete and sign the following:

---

**INDUSTRIAL INJURY PHYSICIAN DESIGNATION**

---

Employee Name: \_\_\_\_\_

Employee # \_\_\_\_\_

Employee Work Telephone No. : \_\_\_\_\_

Court: \_\_\_\_\_

Dept. # \_\_\_\_\_

☐ I do not want to designate a personal physician

☐ I do want to designate my personal physician who has treated me and retains my medical records.  
I have notified my physician of this arrangement and he/she has agreed to file prompt and complete medial reports and to adhere to the Workers' Compensation Medical Fee Schedule.

Designated Personal Physician/Medical Group: \_\_\_\_\_

Physician/Medical Group Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

I HAVE READ THE ABOVE STATEMENT REGARDING INDUSTRIAL INJURY/ILLNESS PHYSICIAN DESIGNATION. THIS FORM CANCELS AND REPLACES ANY PREVIOUS DESIGNATION SIGNED BY ME FOR THIS PURPOSE AND SHALL REMAIN IN EFFECT UNTIL CANCELLED BY ME.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

cc: Personnel File  
Division/Section Head  
Employee  
a:physdes.form

**APPENDIX 10: Designation of Personal Physician**

COUNTY OF LOS ANGELES  
SOUTHEAST MUNICIPAL COURT  
Telephone Number (213) 563-4011  
(213) 586-6353

FOLLOW-UP MEDICAL REPORT

TO: ATTENDING PHYSICIAN OR MEDICAL FACILITY

When an employee of the Southeast Municipal Court requires additional medical treatment as a result of an industrial injury / illness, we would appreciate you completing this form as the time medical treatment is provided. The completed form should be given to the patient for return to the Court.

The Southeast Municipal Court Worker's Compensation Claims are managed by Firm Solutions / PHT & Associates, P. O. Box 19775, Irvine, California 92713-9775 (800) 782-5888. Please send all bills for medical services to the Irvine address.

Employee Name

Division

Description of Injury / Illness

Date of Injury / Illness

Description of Follow-up Medical Treatment

Assessment of Employee's Present Conditions:

☐

Patient is able to work at once without restrictions.

☐

Patient is able to return to work at once with the following restrictions or limitations:

Estimated duration of work restrictions \_\_\_\_\_ calendar days.

☐

Patient should not return to work at once. Patient is to be disabled from (date) \_\_\_\_\_ through (date) \_\_\_\_\_. Date and hour of next appointment: \_\_\_\_\_  
Date of this Report: \_\_\_\_\_.

Name of Physician

Physicians Signature:

Address

Phone No.

**Date:**

Employee Name

Address

City

Dear \_\_\_\_\_ :

Employee No. : \_\_\_\_\_

We have received notice that you believe your illness is related to the stress of your employment. This is to inform you that submission of a medical release will be required prior to your returning to work. As you believe your health problems are related to your employment, a statement is needed signed by a licensed clinical psychologist, medical doctor or psychiatrist, explaining the reason a resumption of your previous duties will not be likely to further aggravate your condition.

Please ask your doctor to complete and return the enclosed document directly to me one week before you plan to return to work.

If you have any questions, please call me at (213) \_\_\_\_\_ .

Sincerely,

Division Chief,  
Southeast Municipal Court

cc: Personnel file  
Human Resources  
Court Administrator

Enclosure

**APPENDIX 12: SAMPLE LETTER**

19. Was work resumed immediately? Yes\_\_\_\_ No\_\_\_\_ Unknown\_\_\_\_  
If NO, state duration of absence as of the time of this report. From\_\_\_\_ to\_\_\_\_

20. Was FIRST AID given? Yes\_\_\_\_ No\_\_\_\_  
If YES, by whom? Name\_\_\_\_

21. Did employee receive professional medical care? Yes\_\_\_\_ No\_\_\_\_

Name and address of Doctor\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and address of Hospital or Clinic\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACCIDENT PREVENTION INFORMATION**

22. What improvement in equipment, safeguards, training, etc. would help prevent this type of injury?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supervisor's Signature\_\_\_\_\_

Date\_\_\_\_\_

Reviewed by\_\_\_\_\_  
(manager)

Date\_\_\_\_\_

FOR HUMAN RESOURCES USE ONLY		
SOC. SEC. NO.	Birth Date	Wages
Employee#	Job Item#	
Megaflex YES	NO	
Hire Date	Home Phone	
Address		

Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee No.: \_\_\_\_\_

Dear Doctor \_\_\_\_\_:

Mr./Ms. \_\_\_\_\_ has reported that the stress of his/her employment has caused or aggravated his/her medical problems, thus causing disability and the need for medical treatment.

In the interests of the employee's health, the safety of fellow employees and the public, we are requesting the following information so we can arrive at a decision regarding his/her return to the same duties which he/she feels have caused or contributed to the disability and need for treatment. A Class Specification describing his/her customary duties is attached.

Please return this report to me at \_\_\_\_\_,  
address

\_\_\_\_\_, (an envelope is enclosed). The second copy  
City, State, Zip Code  
is for your records.

If you have any questions about the information needed, please call me at (213)  
\_\_\_\_\_.

Sincerely,

Division Chief,  
Southeast Municipal Court

**TO BE COMPLETED BY ATTENDING PROFESSIONAL**

1. I attended the patient for the present problem from  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_, at intervals of: \_\_\_\_\_.
2. Do you believe the occupational exposure and/or work caused or contributed to the disability and need for medical treatment?  
☐ Yes ☐ No

3. If you feel that the employee's work has caused or contributed to the disability and need for treatment, what factors now exist which cause you to believe that he or she can return to the same work without danger of aggravating the employee's medical condition?

---

---

---

4. Is the patient presently in need of further medical care? If yes, what type of medical Care?

---

---

---

5. Are there any medical restrictions which should be observed by us in attempting to return this employee to work? If yes, please be specify and state how long the restrictions should be observed.

---

---

---

6. Earliest date employee can return to work: \_\_\_\_\_ I am a

\_\_\_\_\_ licensed to practice by the State of \_\_\_\_\_

\_\_\_\_\_  
State License Number

\_\_\_\_\_  
Print or Type Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

Attachment (s)

Dear

The Workers' Compensation Claims Unit of Firm Solutions, Inc. / PHT & Associates has been notified of your industrial injury of \_\_\_\_\_. They will make the determination on the compensability of this injury for medical treatment and temporary disability (TD) payments.

**Benefits**

1. If your time off from work is determined to be compensable your claims adjuster will send a benefit notice to both you and to the Southeast Municipal Court. Your timekeeper records your time card to reflect your approved benefits.
2. Approved benefits will be 70% of salary for a minimum of one year from date of injury.

The above TD benefits begin on the fourth day after the injury unless you are hospitalized or you are disabled beyond 14 days. Accrued time used prior to receipt of TD is restored to you at a rate of 70% until one year has elapsed from the state of the injury (or your continuous service date prior to the injury, which ever is less).

**Your Claim**

A physician must verify all periods of disability for Workers' Compensation to authorize benefits. To avoid unnecessary delay in receiving your benefits, advise the doctor to send medical reports to Firm Solution / PHT & Associates, P. O. Box 19775, Irvine, California 92713-9775 Attention Municipal Court Adjuster. The claims adjuster is available to answer any questions you may have regarding the status of your claims or other Workers' Compensation benefits. Their telephone number is (800) 782-5888.

**Returning to Duty**

When you return to work you will need to present a letter from your physician releasing you to full duties. If your release includes work restrictions, you must inform the supervisor or Division Chief prior to your return.

**Reporting to your Supervisor**

You are required to report regularly the status of your disability to your immediate supervisor or to the Division Chief. The Court Administrator may require further certification of your disability.



If you have questions that cannot be answered by your supervisor, division chief, or the claims adjuster, you may contact me at (213) 586-6351.

We wish you a speedy recovery.

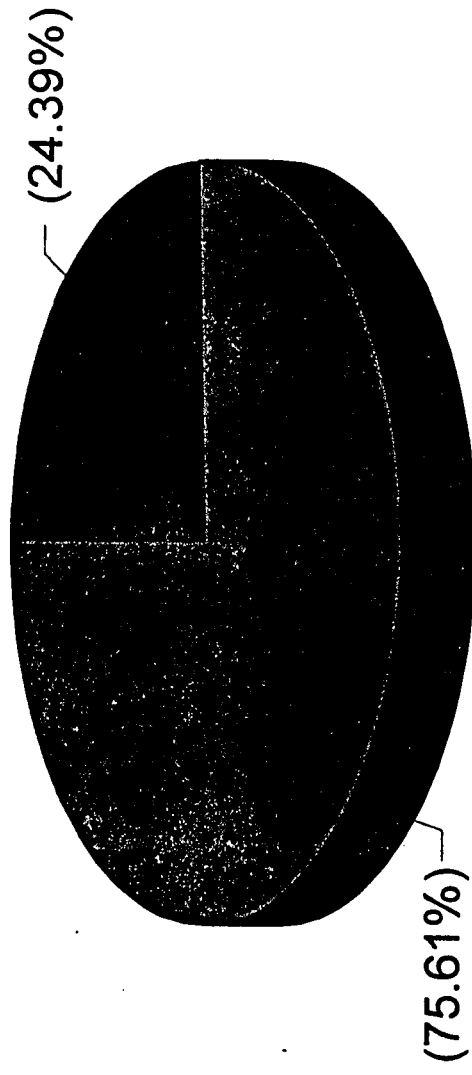
Very truly yours,

Shirley J. Flowers  
Court Administrator

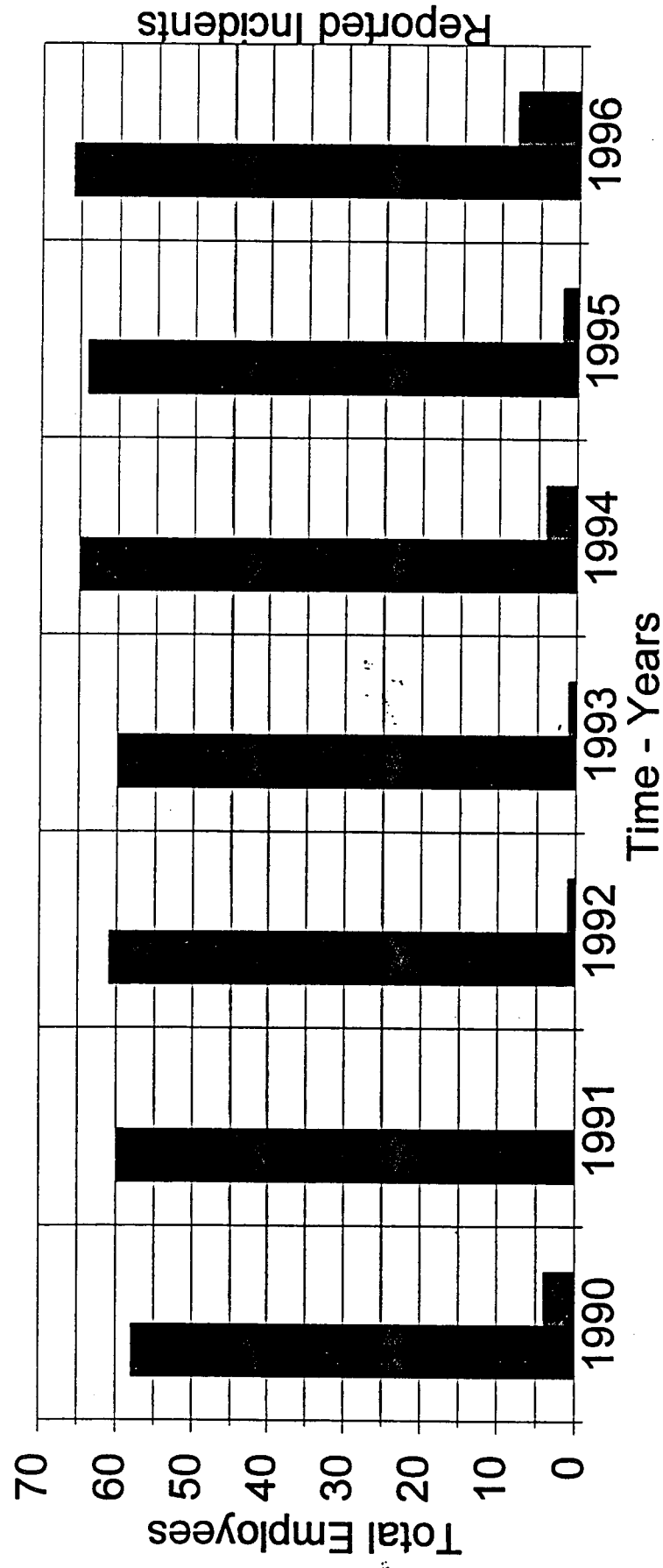
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Division Chief  
Personnel File

# Open Workers Compensation Cases

Total Cases (1990-1996)



# Open Workers Compensation Cases



## 7d Poisioning (Systemic Toxic Materials)

Examples: Poisoning by lead, mercury, cadmium, arsenic; other metals; poisoning by carbon monoxide, hydrogen cyanide or other gases; poisoning by benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays such as parathion, lead arsenate; poisoning by other chemicals such as formaldehyde, plastics, and resins, etc.

### 7e. Disorders Due to Physical Agents (Other than Toxic Materials)

**Examples:** Heartstroke, sunstroke, heat exhaustion, and effects of environmental heat freezing, frostbite, and other exposure to low temperatures cause disease effects of exposure to isotopes, X-rays, radium; effects of nonionizing radiation (ultraviolet rays, microwaves, sunburn; ionizing radiation, ultraviolet rays, microwaves, sunburn).

## 7f. Disorders Associated With Repeated Trauma

**Examples:** Noise-induced hearing loss; synovitis, tenosynovitis, and bursitis; Raynaud's phenomenon; and other conditions associated with repeated motion, vibration, or pressure.

## 7a All Other Occupational Illnesses

Examples: Anthrax, brucellosis, infectious hepatitis, meningitis and benign tumors, food poisoning, histoplasmosis, coccidiosis, etc.

**MEDICAL TREATMENT** includes treatment (other than first aid) administered by a physician or by registered professional personnel under standing orders of a physician. Medical treatment does NOT include first aid treatment (one-time treatment) and subsequent observation of scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care, even though provided by a physician or registered professional personnel.

**ESTABLISHMENT:** A single physical location where business is conducted or where services or industrial operations are performed (for example, a factory, mill, store, hotel, restaurant, movie theater, farm, ranch, sales office, warehouse, or central administrative office). Where distinct separate activities are performed at a single physical location such as a construction activity operated from a single physical location as a turn-out road activity shall be treated as a separate establishment.

For firms engaged in activities which may be physically dispersed, such as agriculture; construction; transportation; communications and electric, gas, and sanitary services, records may be maintained at a place to which employees report each day.

Records for personnel who do not primarily report or work at a single establishment, such as traveling salesmen, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel coverage is carried out their activities.

**WORK ENVIRONMENT** is comprised of the physical location, equipment, materials processed or used, and the kinds of operations performed in the course of an employee's work, whether on or off the employer's premises.

[illegible]

Confidentiality of A	Confidentiality of B	Time	Date
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## Certification of Annual Summary Totals By

**POST ONLY THIS PORTION OF THE LAST PAGE NO LATER THAN FEBRUARY 1.**

CAI/NSA No 200

## APPENDIX: 17 Industrial Injury Claim Log

PROOF OF SERVICE BY MAIL

Employee's Claim For Workers' Compensation Benefits

I, \_\_\_\_\_ declare, I am, and was at the time of this service over 18 years of age.

I served an EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS form on \_\_\_\_\_, 19\_\_\_\_ by depositing one copy of said document in the United States Mail, at \_\_\_\_\_, in \_\_\_\_\_, Los Angeles County, California. The document was in a sealed envelope with the postage fully prepaid, addressed to : \_\_\_\_\_

\_\_\_\_\_  
(State full name and address of addressee as it appeared on the envelope.)

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

\_\_\_\_\_  
(Name - Please print)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Department)

\_\_\_\_\_  
(Business Address)

**(10324) Sample Form:**

[illegible]

## COUNTY OF LOS ANGELES MEDICAL SERVICE ORDER

Dr. \_\_\_\_\_ Address \_\_\_\_\_

We are sending \_\_\_\_\_ to you for treatment in accordance with the terms of the Workers' Compensation Laws. Please send your "Doctor's First Report" to The Noetics Group, L.A. County Workers' Compensation Claims Unit, 15326 Alton Parkway, Irvine, CA 92718.

Department \_\_\_\_\_

Supervisor's Signature & Date \_\_\_\_\_

*RETURN TO EMPLOYEE after examination. This is essential for County pay records.*

Date of this visit \_\_\_\_\_ Date employee states he/she was injured \_\_\_\_\_

NOTE: Limited duty is available for most County employees.

In your opinion is this employee compelled to be absent from work because of the injury? ☐ Yes ☐ No

If Yes, estimated period of recuperation:

Regular working days  Limited duty days

Specify limitations or restrictions \_\_\_\_\_

EMPLOYEE: Return this card to your Department by mail, or in person.

Physician's Signature \_\_\_\_\_

76M119.N (Rev. 1-92)

RBF 1954

## COUNTY OF LOS ANGELES MEDICAL SERVICE ORDER

Dr. \_\_\_\_\_ Address \_\_\_\_\_

We are sending \_\_\_\_\_ to you for treatment in accordance with the terms of the Workers' Compensation Laws. Please send your "Doctor's First Report" to The Noetics Group, L.A. County Workers' Compensation Claims Unit, 15326 Alton Parkway, Irvine, CA 92718.

Department \_\_\_\_\_

Supervisor's Signature & Date \_\_\_\_\_

*RETURN TO EMPLOYEE after examination. This is essential for County pay records.*

Date of this visit \_\_\_\_\_ Date employee states he/she was injured \_\_\_\_\_

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Regular working days  Limited duty days

Specify limitations or restrictions \_\_\_\_\_

EMPLOYEE: Return this card to your Department by mail, or in person.

Physician's Signature \_\_\_\_\_

76M119.N (Rev. 1-92)

RBF 1954

## APPENDIX 19: MEDICAL SERVICE ORDER

DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF INDUSTRIAL ACCIDENTS  
WORKERS' COMPENSATION APPEALS BOARD

CASE NO.

*Applicant*

vs.

*Defendant*

Order  
of  
Dismissal

IT IS ORDERED that the above-entitled Case be, and the same hereby is, dismissed without prejudice.

\_\_\_\_\_  
Referee, WORKERS' COMPENSATION APPEALS BOARD

Dated \_\_\_\_\_

Service by mail on parties  
shown on Official Address Record  
effected on above date.

BY: \_\_\_\_\_

1190-C 12/88





## **Glossary of Terms**

**Annual summary.** Consist of a copy of the occupational injury and illness totals for the year from the OSHA No. 200, and the following information: The calendar year covered; company name; establishment address; certification signature, title and date.

**Annual Survey.** Each year, BLS conducts an annual survey of occupational injuries and illnesses to produce national statistics. The OSHA injury and illness records maintained by employers in their establishments serve as the basis for this survey.

**Bureau of Labor Statistics (BLS).** The Bureau of Labor Statistics is the agency responsible for administering and maintaining the OSHA recordkeeping system and for collecting, compiling, and analyzing work injury and illness statistics.

**Certification.** The person who supervise the preparation of the Log and Summary of Occupational Injuries and Illnesses, OSHA No. 200, certifies that it is true and complete by signing the last page of, or by appending a statement to that effect to, the annual summary.

**Cooperative program.** A program jointly conducted by the States and Federal Government to collect occupational injury and illness statistics.

**Employee.** One who is employed in the business of his or her employer affecting commerce.

**Employee representative.** Anyone designated by the employee for the purpose of gaining access to the employer's log of occupational injuries and illnesses.

**Employer.** Any person engaged in a business affecting commerce who has employees.

**Establishment.** A single physical location where business is conducted or where services or industrial operations are performed; the place where the employees report for work, operate from, or from which they are paid.

**Exposure.** The reasonable likelihood that a worker is or was subject to some effect, influence or safety hazard; or in contact with a hazardous chemical or physical agent at a sufficient concentration and duration to produce an illness.

**Federal Register.** The official source of information and notification on OSHA's proposed rulemaking, standards, regulations, and other official matters, including amendments, corrections, insertions, or deletions.

**First-aid.** Any one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care. Such treatment and observation are considered first aid even though provided by a physician or registered professional personnel.

**First report of Injury.** A workers' compensation form which may qualify as a substitute for the supplementary record, OSHA No. 101.

**Incidence rate.** The number of injuries, illnesses, or lost work days related to a common exposure base of 100 full-time workers. The common exposure base enables one to make accurate interindustry comparison, trend analysis over time, or comparisons among firms regardless of size. This rate is calculated as:

$$N/EH \times 200,000$$

where:

N = number of injuries and/or illnesses or lost work days.  
EH = Total hours worked by all employees during calendar year  
200,000 = base for 100 full time equivalent workers (working 40 hr. per week, 50 weeks per year).

**Log and Summary (OSHA No 200)** The OSHA recordkeeping form used to list injuries and illnesses and to note the extent of each case.

**Lost workday cases.** Cases which involve days away from work or days of restricted work activity, or both.

**Lost workdays.** The number of workdays (consecutive or not), beyond the day of injury or onset of illness, the employee was away from work or limited to restricted work activity because of an occupational injury or illness.

(1) *Lost workdays--away from work.* The number of work days (consecutive or not) on which the employee would have worked but could not because of occupational injury or illness.

(2) *Lost workdays--restricted work activity.* The number of workdays (consecutive or not) on which, because of injury or illness: (1) The employee was assigned to another job on a temporary basis; or (2) the employee worked at a permanent job less than full time; or (3) the employee worked at a permanently assigned job but could not perform all duties normally connected with it.

The number of days away from work or days of restricted work activity does not include the day of injury or onset of illness or any days on which the employee would not have worked even though able to work.

**Medical treatment.** Included treatment of injuries administered by physicians, registered professional personnel, or lay persons ( i.e. nonmedical personnel). Medical treatment does not include first aid treatment (one-time treatment and subsequent observation of minor scratches cuts, burns splinters, and so forth, which do not ordinarily require medical care) even though provided by a physician or registered professional personnel.

**Notice or Knowledge:** Under the Workers' Compensation laws, knowledge or notice of an industrial injury occurs when knowledge of the occurrences of an industrial injury is obtained from any source on the part of an employer, its managing agent, superintendent, foremen, or other person in authority or knowledge of the assertion of a claim of injury / illness sufficient to afford the opportunity to the employer to make an appropriate investigation into the facts.

**Occupational illness.** Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. It includes acute and chronic illness or diseases which may be caused by inhalation, absorption, ingestion, or direct contact.

**Occupational injury.** Any injury such as a cut, fracture, sprain, amputation, etc., which results from a work accident or from a single instantaneous exposure in the work environment.

*Note: Conditions resulting from bites, such as insect or snake bites, and from one-time exposure to chemicals are considered to be injuries.*

Occupational injuries and illnesses extent and outcome. All recordable occupational injuries or illnesses result in either:

- (1) *Fatalities, regardless of the time between the injury, or the length of illness, and death;*
- (2) *Lost workday cases, other than fatalities, that result in lost workdays;*  
*or*
- (3) *Non fatal cases without lost workdays.*

**Occupational Safety and Health Administration (OSHA).** OSHA is responsible for developing, implementing, and enforcing safety and health standards and regulations. OSHA works with employers and employees to foster effective safety and health programs which reduce workplace hazards.

**Personal physician.** means the employee's regular Doctor of Medicine (M.D.) or Doctor of osteopathy (D.O.), licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. (Labor Code Section 4600)

**Posting.** The annual summary of occupational injuries and illnesses must be posted at each establishment by February 1, and remain in place until March 1, to provide employees with the record of their establishment's injury and illness experience for the previous calendar year.

**Recordable cases.** All work-related deaths and illnesses and those work-related which result in: Loss of consciousness, restriction of work or motion, transfer to another job, or require medical treatment beyond first aid.

**Recordkeeping system.** Refers to the nationwide system for recording and reporting occupational injuries and illnesses mandated by the Occupational Safety and Health Act of 1970 and implemented by Title 29, Code of Federal Regulations, Part 1904. This system is the only source of national statistics on job-related injuries and illnesses for the private sector.

**Regularly exempt employers.** Employers regularly exempt from OSHA recordkeeping include: (A) All employers with no more than 10 full- or part-time

employees at any one time in the previous calendar year; and (B) all employers in retail trade; finance, insurance, and real estate; and services industries.

**Report Form.** Refers to survey form OSHA No. 200-S which is completed and returned by the surveyed reporting unit.

**Restriction of work or motion.** Occurs when the employee, because of the result of a job-related injury or illness, is physically or mentally unable to perform all or any part of his or her normal assignment during all or any part of the workday or shift.

**State (when mentioned alone).** Refers to a State of the United States, the District of Columbia, and U.S. territories and jurisdictions.

**State Agency.** State agency administering the OSHA recordkeeping and reporting system. Many States cooperate directly with BLS in administering the OSHA recordkeeping and reporting programs. Some States have their own safety and health laws which may impose additional obligations.

**Supplemental Record (OSHA No. 101).** The form (or equivalent) on which additional information is recorded for each injury and illness entered on the log.

**Volunteers.** Workers who are not considered to be employees under the act when they serve of their own free will without compensation.

**Work environment.** Consist of the employer's premises and other locations where employees are engaged in work-related activities or are present as a condition of their employment. The work environment included not only physical locations, but also the equipment or materials used by the employee during the course of his or her work.

**Workers' compensation system.** State systems that provide medical benefits and/or indemnity compensation to victims of work-related injuries and illnesses.



