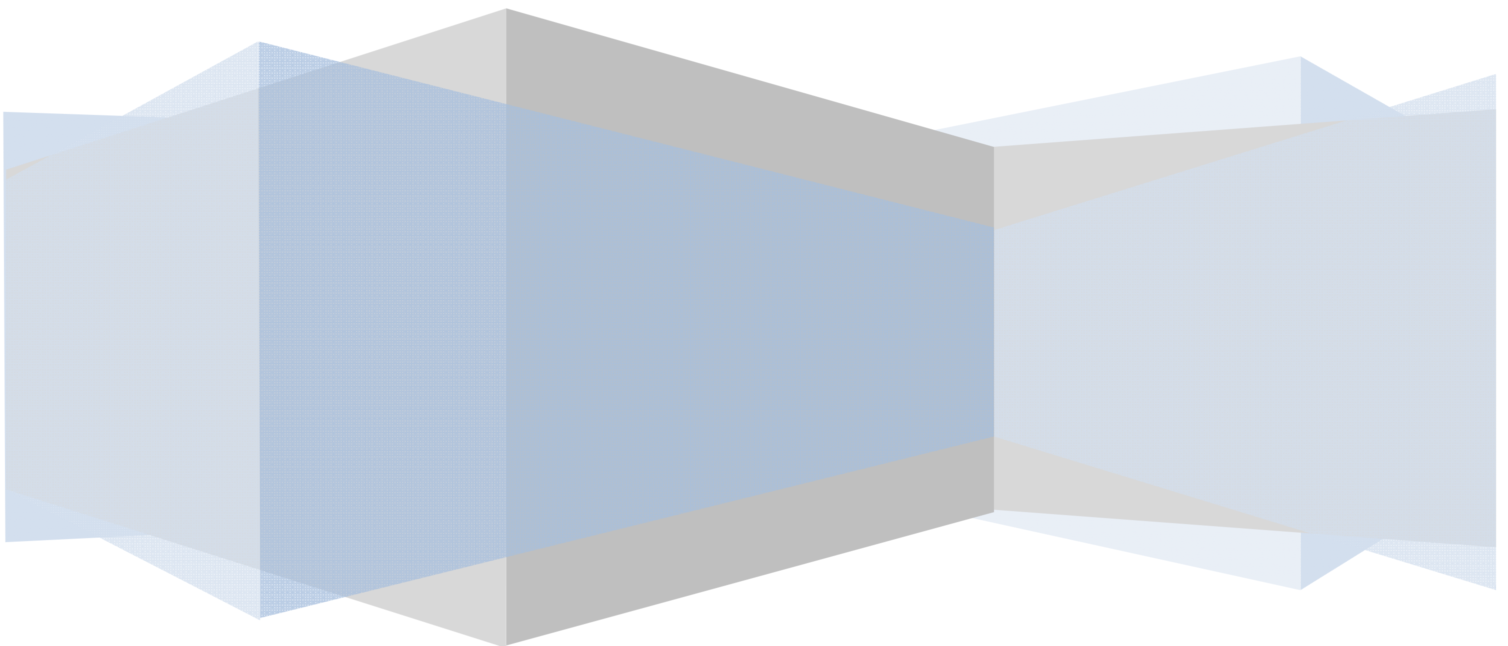
Cerritos College
11110 Alondra Blvd.
Norwalk, CA 90650
(562) 860-2451

Workers' Compensation

REPORTING A JOB-RELATED INJURY/ILLNESS



Risk Management

Workers' Compensation Procedures

1. What is Workers' Compensation?

Workers' Compensation is a state-run insurance system that provides income protection for workers experiencing job-related injuries or illnesses. The Cerritos Community College District Workers' Compensation Insurance covers Cerritos College employees injured on the job or suffering an illness caused by the job.

2. Procedures

It is required that any employee who sustains a job-related injury/illness immediately reports the injury/illness to his/her immediate manager or supervisor.

- **Emergency: Serious Job-Related Injury or Illness**

  A serious injury or illness is one that requires inpatient hospitalization for more than 24 hours for something more than medical observation; or one in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

  - NORMAL WORKING HOURS: The serious injury or illness of an employee must be reported by a manager or Campus Police Officer to a District Workers' Compensation Coordinator **immediately** after he/she becomes aware of the serious injury or illness. The District Workers' Compensation Coordinator will report the incident to CalOSHA. The District is required to report serious job related injuries or illnesses to the State agency within 8 hours.

  - OUTSIDE WORKING HOURS: In cases of serious injury or illness of an employee, the manager should notify Campus Police immediately by dialing 911 from a District phone or by dialing the direct line to Campus Police at (562) 402-3674.

- ## Non-Emergency Normal Business Hours

  - Reporting a Job-related Injury/Illness

    If an employee is injured on the job or suffers an illness caused by the job, he/she must immediately (**within 24 hours**) contact the immediate manager or supervisor. The manager of the area will give to the employee the Workers' Compensation Claim form (DWC 1) (**Sample 1**). The employee must complete questions 1 through 8 (top portion). The employee should keep the green copy (Temporary Receipt) or a photocopy of the DWC 1 after he/she completes the top portion.

    If the employee declines to accept the DWC 1, he/she must complete and sign the Employee's Declination of Workers' Compensation/ Treatment form (**Sample 2**).

    NOTE: If the immediate manager or supervisor is not available, the employee must contact any other District manager within 24 hours and notify his/her immediate manager when he/she becomes available.

  - Receiving Medical Treatment

    If medical treatment is needed, the employee must be referred to Health First Medical Group or to his or her pre-designated physician (pre-designation must be on file prior to injury/illness). Health First Medical Group is open 24 hours, 7 days a week. The manager must complete and give to the employee the Authorization to Treat form (**Sample 3**).

    Health First Medical Group
    13440 E. Imperial Hwy.,
    Santa Fe Springs, CA 90670

    Telephone: (562) 926-3440

If the employee declines medical treatment, he/she must complete and sign the Employee's Declination of Workers' Compensation/ Treatment form (**Sample 2**).

NOTE: Employees are required to report all job-related injuries, including injuries requiring only First Aid treatment. First Aid injuries may be treated at the Student Health Services. First Aid refers to medical attention that is usually administered immediately after the injury occurs. It often consists of a one-time, short-term treatment and requires little technology or training to administer.

- Manager's Report of Job-related Injury/Illness

After the employee has completed the DWC 1 and has been referred for medical treatment, the manager must complete questions 9 through 13 of the DWC 1 form (lower portion). A District Workers' Compensation Coordinator will complete questions 14 through 18.

The manager must contact a District Workers' Compensation Coordinator immediately or **within 24 hours** to report the job-related injury/illness.

- District Workers' Compensation Coordinators

Primary Contact: Michael Meadors, Human Resources Analyst
Extension: 2291

Secondary Contact: Nancy Buvinger, Director, HR & Risk Management
Extension: 2283

Third Contact: Deanna Hart, Payroll Manager
Extension: 2275

The manager must complete Supervisor's Accident Investigation/ Injury and Illness Incident Report (**Sample 4**) for all job related incidents, including First Aid injuries, and submit with the completed DWC 1, when applicable, to a District Workers' Compensation Coordinator. The manager must state what steps have been taken to prevent similar injuries/illnesses.

- Non-Emergency Outside Normal Business Hours

  If the injury occurs outside normal business hours and the immediate manager or any District manager is not available, the employee should go to the Campus Police Office to report the injury/illness and pick up the required forms. Campus Police staff will complete and give to the employee the Authorization to Treat form (**Sample 2**).

  Campus Police will contact the injured employee's immediate manager within the next business day to report the employee's injury/illness. The manager will take over and meet with the employee, complete required forms, and contact a District Workers' Compensation Coordinator.

3. Treating Physician

Any employee who sustains a job-related injury/illness will be referred to Health First Medical Group, unless the employee has pre-designated his/her personal physician by submitting the Workers' Compensation Pre-Designation of Personal Physician form (**Sample 5**). The Pre-Designation form must be in the District Workers' Compensation Coordinator's files prior to an injury/ illness.

4. Absence Due to Job-related Injury/Illness

Any employee who is absent because of injury or illness which arose out of and in the course of his/her employment can receive temporary disability benefits. Please refer to collective bargaining agreements and Board Policy.

5. Release to Return to Work

Any employee who is released to return to work after a job-related injury/ illness, must present required documentation and follow procedures. Please refer to collective bargaining agreements and Board Policy.

6. Questions

The District is committed to ensuring the safety of employees and students on District sites. Employees are required to follow safe work practices and use safety equipment as required by their job at all times.

Any questions regarding these procedures, contact Nancy Buvinger, Director of Human Resources and Risk Management, extension 2283.

Sample 1

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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.

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

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

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

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

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

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

9. Name of employer. *Nombre del empleador.* ______________________
10. Address. *Dirección.* ______________________
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ______________
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ______________
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ______________
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* ______________________________
15. Insurance Policy Number. *El número de la póliza de Seguro.* ______________________
16. Signature of employer representative. *Firma del representante del empleador.* ______________________
17. Title. *Título.* ______________ 18. Telephone. *Teléfono.* ______________

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

Sample 2

Employee's Declination of Workers' Compensation/Treatment

Name of Injured/Ill Employee: ____

Job Title: ______________________________ Work Site:______________________________

Date of injury/illness: ________________________ Time of injury/illness: ___________ AM/PM

Date reported: _______________ Time reported: ________ AM/PM To whom? _____________

☐ DECLINATION TO COMPLETE DWC 1 CLAIM FORM

If employee declines to accept forms, they must read, understand, and sign below.

I have been offered the Workers' Compensation Claim Form (DWC-1) and have chosen not to accept and/or complete it. I do not have a desire to file a claim for Workers' Compensation pertinent to the injury/illness described in this report. I understand my rights regarding Workers' Compensation and do not wish to exercise them at this time. I do not need medical attention for this injury/illness.

____________________________	______________	____________________________
Employee's Full Name (print)	Date	Employee's Signature

☐ DECLINATION TO RECEIVE MEDICAL TREATMENT

If the employee declines medical treatment, yet wishes to report the injury, provide Workers' Compensation Claim Form (DWC-1) to the injured/ill employee. The employee must sign below, indicating he/she has received the above-mentioned forms, been offered medical attention and has chosen to decline medical treatment.

I have declined to accept medical treatment offered to me for the injury/illness discussed in this form.

____________________________	______________	____________________________
Employee's Full Name (print)	Date	Employee's Signature

Upon completion of this form, immediately forward with the Supervisor's Accident Investigation/Injury and Illness Incident Report to hr@cerritos.edu

Sample 3

AUTHORIZATION TO TREAT

HEALTH + FIRST Medical Group

INJURIES
24 Hours
7 Days a Week

HEALTHFIRST MEDICAL - **SOUTH**
13440 E. Imperial Hwy., Santa Fe Springs, CA 90670 • **(562) 926-3440**

☐ **Initial Injury** ☐ **Drug Screen on Injury** **Body Part Injured** ______

Physicals/Drug Screens 8:00 am - 4:30 pm
Picture I.D. Required!

☐ Post Offer Physical ☐ Drivers DOT Physical ☐ Hepatitis [illegible]
☐ Return to Work Physical ☐ Federal Drug Screen ☐ [illegible] Function Test
☐ Drug Screen ☐ [illegible] ☐ [illegible]

Patient Name: ______

Company Name: ______

Job Classification: ______

Modified Duty Available: Yes No

Insurance Name: ______

Does employee work for Temp/Leasing Co. ☐ YES ☐ NO **Tel. #** ______

TODAYS DATE: ______

EXPIRES ON: ______

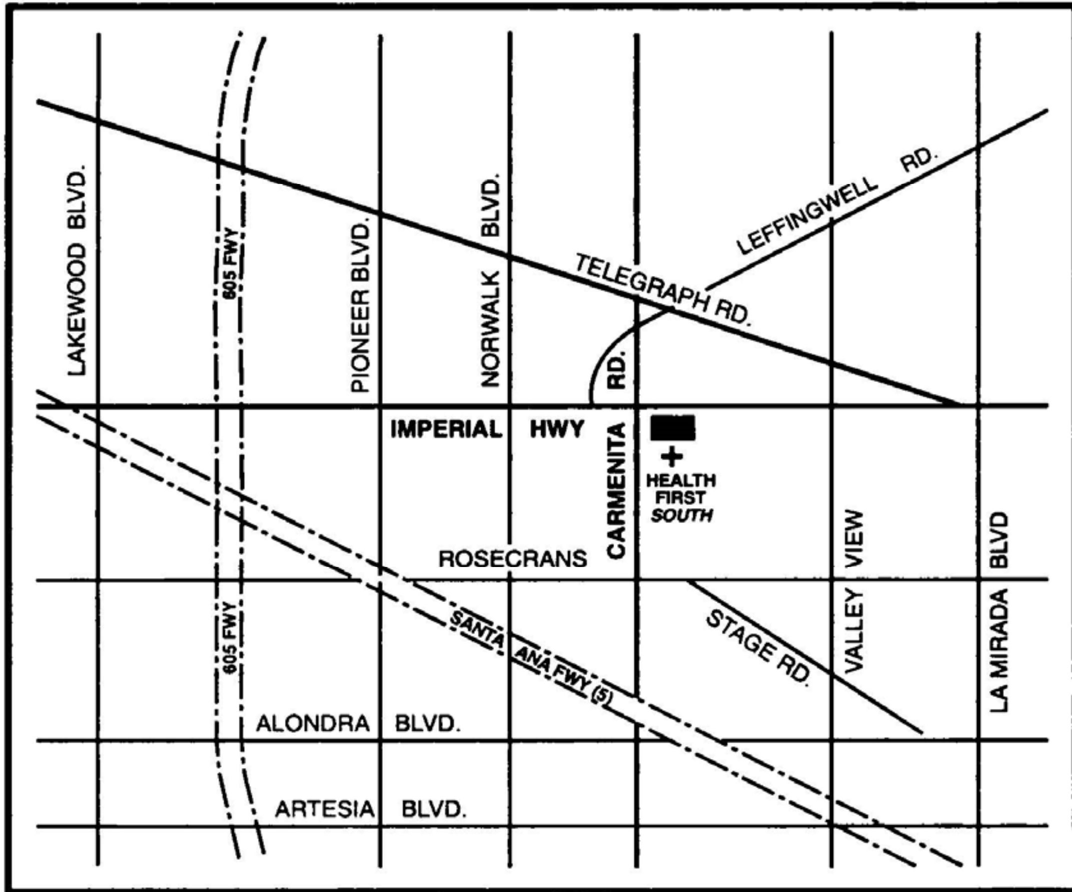
☐ VERBAL

______
AUTHORIZED COMPANY SIGNATURE

SEE MAP ON OPPOSITE SIDE

SAMPLE

24 Hours a Day - 7 Days a Week
***HEALTHFIRST MEDICAL* SOUTH**
(562) 926-3440



Sample 4

Supervisor's Accident Investigation/ Injury and Illness Incident Report

It is mandatory that this Injury and Illness Incident Report form be completed by a Manager/Supervisor for all employee work-related injuries/illnesses, regardless of whether or not medical attention is required. Please complete form thoroughly.

Name of Injured/Ill Employee: ______________________________

Last four Digits of Social Security Number: __________ Job Title: ______________________

Work Site: ______________________ Hours of Employment: __________ (Start Time/End Time) ☐M ☐T ☐W ☐Th ☐F ☐S ☐S (days of Week Scheduled)

Date of injury/illness: ______________________ Time of injury/illness: ______ ☐ AM ☐ PM

Date reported: __________ Time reported: ______ ☐ AM ☐ PM To Whom? ______________

Describe injury/illness. (Provide specific part(s) of body affected and how it was affected. Examples: cut to left forearm; chemicals splashed in right eye; twisted left knee.):

Describe where injury/illness occurred. (In addition to site/location, provide detailed location information. Example: Liberal Arts building, classroom # LA-20)

Describe how injury/illness occurred. (Provide description of what the employee was doing at the time of injury, equipment being used, etc. Example: Climbing a ladder when ladder slipped on wet floor, worker fell 20 feet landing on floor; filling bottles with cleaning chemicals when chemicals splashed into eyes.):

Was this injury/illness witnessed? Provide witness information (name, address, telephone number):

Did injured/ill employee leave work? ☐ Yes ☐ No Date: __________ Time: ______ ☐ AM ☐ PM

Did injured/ill employee return to work? ☐ Yes ☐ No Date: __________ Time: ______ ☐ AM ☐ PM

Is there a safety issue or condition at the job site which needs immediate attention? ☐ Yes ☐ No

What action is needed to prevent a similar accident from occurring?

Has a work order been processed for corrective action? ☐ Yes ☐ No

If yes, work order # ______________________ (Copy of above cited work order attached)

What actions have been taken to ensure the safety of students and other employees?

What, if any, safety equipment had been provided to injured worker? Was equipment being used at time of injury?

Comments:

Use a separate sheet of paper if necessary.

Completed by: ______________________________

Title: ______________________________

Site: ______________________________

Date: ______________ Time: ________ ☐ AM ☐ PM

Upon completion of this form, immediately forward with the DWC 1 claim form to hr@cerritos.edu.

Sample 5

CERRITOS COLLEGE

Workers' Compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated**, **personal physician**, **the physician must agree, in writing, to treat you for a work related injury,** must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, pediatrician or a multi-specialty medical group, whose practice is predominantly for non-occupational injuries or illnesses.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer **in writing prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated worker's compensation medical providers.

EMPLOYEE NAME: ____

❑ **I acknowledge receipt of this form and elect not** to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employer's medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: ________________________________ Date: ____________

❑ **If I am injured on the job, I wish to be treated by my personal physician***:

Name of Physician ______________________________ Phone Number ______________

Physician Address ____

*This physician is my personal physician who has previously directed my medical care and retains my medical history and records.

Employee Signature: ________________________________ Date: ____________

A *Personal Physician* must be willing to be predesignated and treat you for a worker's compensation injury. ***The remainder of this form is to be completed by your physician and returned to your Employer.***

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other **written** documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME: ____

❑ ***I agree to treat*** **the above named employee in the event of an industrial accident or injury**. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

❑ ***I do not agree* to treat the above employee in the event of an industrial accident or injury.**

❑ ***I do not qualify* as the employees' personal physician**. I am not an M.D. or D.O. or do not meet the criteria outlined above.

________________________________ ______________
Physician Signature Date

Please return completed form to:

Cerritos College/11110 Alondra Blvd., Norwalk, CA 90650/Attn: Human Resources | hr@cerritos.edu