

TREATMENT CENTER LIST FOR OJT STUDENTS AND DISTRICT EMPLOYEES INJURED ON THE JOB - ROP CLASSROOM INJURIES CARED FOR BY STUDENT'S PERSONAL PHYSICIAN - CALL 911 IN EMERGENCIES AND CONTACT PARENTS IMMEDIATELY

**WORKER'S COMPENSATION
DISTRICT AUTHORIZED TREATMENT CENTERS
FOR OJT STUDENTS INJURED ON THE JOB**

US HEALTHWORKS
25733 Rye Canyon Road
Valencia, CA 91355
(661) 295-2500
Hours Monday - Friday 8am - 5pm

SCV QUALITY CARE
23929 Mc Bean Parkway #100
Valencia, CA. 91355
(661) 254-0026 FAX (661) 254-1773
Hours Monday - Friday 8am - 8pm
Saturday - Sunday 9am- 6pm

US HEALTHWORKS
22840 Soledad Canyon Road
Saugus, CA. 91350
(661) 799-1776
Hours Monday-Friday 8am - 8pm
Saturday-Sunday 8 am-6 pm

**SANTA CLARITA ADVANCED MEDICAL
PROVIDENCE MEDICAL**
27878 Smythe Drive
Valencia, CA. 91355
(661) 294-1030 FAX (661) 294-0931
Hours Monday - Friday 8am - 8pm
Saturday - 9am - 3pm

US HEALTHWORKS- VAN NUYS
16300 Roscoe Blvd Suite 1-A
Van Nuys, CA. 91406
(818) 893-4426
Open 24 hours 7 days a week

KAISER ON THE JOB (OCCUPATIONAL ONLY)
13652 Cantara Street
Panorama City, CA. 91402
(818) 375-2233
Hours Monday - Friday 8:30 am - 5pm

FOR EMERGENCY ONLY - OR AFTER HOURS***

HENRY MAYO HOSPITAL ***
23845 McBean Parkway
Valencia, CA. 91355
(661) 253-8000

PROVIDENCE HOLY CROSS HOSPITAL ***
15031 Rinaldi Street
Mission Hills, CA. 91346
(818) 365-8051

After initial visit to a treatment center, you may choose to make an appointment with one of our NETWORK PROVIDERS by going to the following website: www.eiampn.csac-eia.org.

SUPERVISOR'S ACCIDENT/ILLNESS REPORT AND INVESTIGATION GUIDELINES

OVERVIEW

An employee injured on the job is required to report the injury to his/her supervisor as soon as possible after the incident/accident. The supervisor is responsible first, to assure that any injured employee is given immediate and proper medical care (as required) and that no one else can be injured and, second, to immediately (within 8 hours) contact the Business Services office (xXXXX) to report the accident. Business Services staff is available to assist the supervisor with the accident investigation.

The purpose of accident investigation is to develop information on the actual and contributing causes of accidents in order to prevent recurrence. Our goal is to find and remove accident causes and to make the District a safer place to work. Accident investigations help us meet that goal.

The following is a brief overview of the investigation and report form that is required for every employee accident. All blanks should be filled in.

GENERAL INFORMATION

This section identifies the injured employee, the department and employee status.

ACCIDENT DATA

This section describes the accident with specifics on what the injured employee was doing and which body parts (right hand, left lower leg, back of head) were affected. The specific time and place (building, room, area) of the accident is important in the investigation.

The type of injury can be described by such terms as: foreign body in eye, cut, puncture, bruise, sprain, strain, fracture, burn, dermatitis, etc.

INVESTIGATION

The investigation section is completed in narrative format and consists of four parts: description of accident, cause of accident, corrective action and industrial injury verification.

Description of Accident

- a. What was the employee doing at the time of the incident?
- b. What sequence of events led to the incident?
- c. What were the working conditions and tools being used?
- d. Any witnesses or contributors to the incident?
- e. How did the accident happen?
- f. Some types include:
 - i. Struck against
 - ii. Struck by an object
 - iii. Caught in or between
 - iv. Slipped
 - v. Tripped
 - vi. Overexertion
 - vii. Inhaled
 - viii. Absorbed
 - ix. Ingested
 - x. Contact with electric current

Cause of Accident

- a. Causes include unsafe acts or equipment as well as poor or improper training.
- b. Other possible causes may include:
 - i. Improper instruction
 - ii. Lack of skill
 - iii. Operation without authority
 - iv. Horseplay
 - v. Physical impairment

- vi. Failure to warn or secure
- vii. Failure to lockout
- viii. Unsafe position or speed
- ix. Improper protective equipment
- x. Poor housekeeping
- xi. Unsafe arrangement
- xii. Hazardous condition
- xiii. Unsafe process or procedure
- xiv. Unsafe lifting or carrying
- xv. Poor ventilation or lighting
- xvi. Improper guarding
- xvii. Improper maintenance
- xviii. Improper safety device
- xix. Improper tool
- xx. Chemical spill
- xxi. Lack of time
- xxii. Work overload
- xxiii. Failure to inspect
- xxiv. Failure to enforce
- xxv. No inspection made
- xxvi. Failure to train

Corrective Action Taken or Recommended

This section describes the corrective action that the supervisor has taken or will take to prevent similar accident from occurring. This may require action from other departments such as Maintenance & Operations for repairs or Business Services for training.

Industrial Injury?

This is where the supervisor verifies that the injury occurred while the employee was on the job and covered by Workers' Compensation. If the supervisor believes that the injury did not happen during the course of employment, an explanation is necessary.

TREATMENT DATA

This section details the treatment provided and who provided it. Note if the employee is off work because of the accidental injury and how long the employee will be off. Is modified duty available for the injured employee to return to work?

The supervisor must sign and date the report.

MISCELLANEOUS

- Examine the accident site and preserve the scene if necessary.
- Take photos or make a diagram if it helps explain the situation.
- Remove/repair unsafe conditions.
- Interview witnesses as necessary.
- Be sure the report is legible.
- Use additional pages as required.

CALL BUSINESS SERVICES – EXTENSION XXXX

- For serious injuries or requiring overnight hospitalization.
- For any injured employee transported off campus for medical care.
- For assistance with the investigation.
- When in doubt.

SUPERVISOR'S ACCIDENT/ILLNESS INVESTIGATION FORM

INSTRUCTIONS:

1. Supervisor to complete this form whenever an employee is involved in an accident that results in an injury (including minor injuries).
2. In addition to completing this form, Supervisor must contact Business Services (x-xxxx, Fax xxxx) to report accident as soon as possible, but no later than 8 hours.
3. Copies of completed form should be sent to Human Resources/Business Services (Mail Drop xxxx). Retain original in department files.

GENERAL INFORMATION

Name of Employee: (print clearly) Last, First, MI		Employer: <input type="checkbox"/> Employee ID# _____ <input type="checkbox"/> Other _____
Work Department:	Job Title:	Status of Employee: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

ACCIDENT DATA

Type of Injury/Illness:	Date and Time of Injury	Date Reported
Job/Activity Being Performed at Time of Incident:	Part of Body Affected	Location of Incident

INVESTIGATION

Description of Incident (please be specific; identify tasks being performed, tools, equipment or materials the employee was using):

Cause of Incident (describe the root cause of accident. Consider factors such as unsafe acts, tool or equipment malfunction, or improper training):

Corrective Action Taken or Recommended: (list on separate page if necessary):

Do you feel this is an industrial injury as reported by the employee? Yes No (Explain)

TREATMENT DATA

Treatment Provider:
 Given First Aid MPN Clinic Outside Clinic Hospital Emergency Room

Diagnosis and Treatment (if known):	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date:	

Printed Name of Supervisor:

Signature: _____ Date: _____ Phone: _____

Reviewed by Human Resources/Business Services:

Signature: _____ Date: _____ Phone: _____



WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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

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

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describe 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 administradora de seguros.*
York Insurance Services Group, Inc. 25379 Wayne Mills Place, #450, Valencia, CA 91355
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.

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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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