LOS ANGELES COMMUNITY COLLEGE DISTRICT

LACCD EH&S

REPORTING OCCUPATIONAL INJURIES AND ILLNESSES

RR-03

LOS ANGELES COMMUNITY COLLEGE DISTRICT

REPORTING OCCUPATIONAL INJURIES AND ILLNESSES

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LOS ANGELES COMMUNITY COLLEGE DISTRICT

REPORTING OCCUPATIONAL INJURIES AND ILLNESSES

I. OBJECTIVES

A. This procedure complies with Title 8, California Code of Regulations, Sections 9770 through 14000 et seq for reporting occupational injuries and illnesses at each campus and at the Educational Services Center *(ESC)*.

B. This procedure complies with Title 8, California Code of Regulations, Section 3203 for investigating reported occupational injuries and illnesses.

C. Each campus may develop and prescribe additional procedures and controls approved by the Vice President - Administration, or equivalent, to meet these objectives, as appropriate.

II. DEFINITIONS

A. *Date of Injury* means the date of the work accident which resulted in the employee's injury or the date upon which the employee first suffered disability from an occupational disease or cumulative injury and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by the employee's present or prior employment.

B. *Date of Knowledge of Injury* means the date the District Workers' Compensation Office, the employee's supervisor, or higher level of supervisor, manager, or administrator has knowledge of an employee's occupational injury or illness.

C. *Date of Onset of Illness* means the date of initial diagnosis of illness or, if absence from work occurred before diagnosis, the first day of the absence attributable to the illness that was later diagnosed or recognized.

D. *Emergency Treatment* means that medical treatment reasonably required by an injured employee immediately following an occupational injury or illness, which, if delayed could decrease the likelihood of maximum recovery.

II. DEFINITIONS *(Continued)*

E. *Employee* means an employee as defined in Section 3351 of the Labor Code. For the purpose of workers' compensation benefits, eligible persons include the following classifications whose injuries or illnesses arise out of and during the course of employment with the District or other covered activities and services:

1. Full-time *(regular)* and part-time employees;

2. District Officers and Board Members;

3. Persons performing voluntary services for the District without pay upon adoption of a resolution by the Board of Trustees *(Labor Code §3363.5)*;

4. Student workers as defined by the most recent revision of the Los Angeles Community Colleges Personnel Guide B385; and

5. Students enrolled in certain applied technology programs such as:

(i) Intern programs;

(ii) Mentoring programs;

(iii) Cal/Works programs;

(iv) Workforce Investment Act programs;

(v) State Chancellor's Office grants;

(vi) Other federal and state grants requiring student workers' compensation coverage as a condition of the grant; and / or

(vii) Under the purview of any course curriculum or District election to provide workers' compensation benefits.

F. *First Aid* means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation, is considered first aid, even though provided by a physician or registered professional personnel.

II. DEFINITIONS *(Continued)*

G. *Injury Inspection / Investigation* means a formal workplace inspection and / or employee interview process.

1. An inspection may be performed in order to assess facility conditions that may have contributed to occupational injury or illness.

2. An investigation may be performed in order to assess employee safe work practices, procedures, personal protective equipment, business operations, and/or other pertinent matters related to the occupational injury or illness.

H. *Lost Time* means absence from work for a full day or shift beyond the date of the injury or illness.

I. *Occupational Illness* means any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. Such illness includes acute and chronic illnesses or diseases that may be caused by inhalation, absorption, ingestion, or direct contact.

J. *Occupational Injury* means any injury such as a cut, fracture, sprain, amputation, etc., which results from a work accident or from an exposure involving a single incident in the work environment.

NOTE: Conditions resulting from animal bites, such as insect or snakebites or from one-time exposure to chemicals, are considered to be injuries.

K. *Recordable Cases* means every occupational death, every nonfatal occupational illness, and those nonfatal occupational injuries which involve:

1. Loss of consciousness;

2. Restriction of work or motion;

3. Lost time *(i.e., days away from work)*;

4. Transfer to another job or termination of employment; or

5. Medical treatment beyond first aid.

III. RESPONSIBILITIES

A. *Workers' Compensation Office (WCO)*

1. The District WCO acts as liaison between each campus and the Third Party Administrator *(TPA)* for all general programs needs.

2. The Employee Benefits Assistant assigned to the WCO reports to the Risk Manager in Business Services Division–Risk Management Section at the ESC.

3. Duties of the Employee Benefits Assistant include, but are not limited to:

   a) Processing claims and reports of occupational injury or illness received from each campus and the ESC in a timely manner as prescribed by the Department of Industrial Relations-Division of Workers' Compensation *(DWC)*;

   b) Submitting claims and reports of occupational injury or illness to the TPA for preservation and maintenance of case files;

   c) Servicing and coordinating special requests for injury investigations and other follow-up information, as needed, between the TPA and each District location;

   d) Preserving and maintaining Cal/OSHA Form 300, *Log of Work-Related Injuries and Illnesses*, if required *(See Section VI Note)*;

   e) Preserving, maintaining, and posting Cal/OSHA Form 300A, *Annual Summary of Work-Related Injuries and Illnesses*, if required;

   f) Providing any special survey information from the Department of Industrial Relations - Division of Labor Statistics and Research;

   g) Preserving and maintaining Cal/OSHA Form 301, *Injury and Illness Incident Report*, or equivalent form that meets the requirements of Form 301, if required;

   h) Preserving and maintaining Form EH&S EC-01-3, *Bloodborne Pathogens Exposure Incident Log*, on behalf of the District; and

   i) Preparing the Division of Industrial Accidents *(DIA)* Form 510, *Notice of Employee Death*, on behalf of the District.

III. RESPONSIBILITIES *(Continued)*

4. The Occupational Safety and Health Specialist provides management consultation and oversight for required Workers' Compensation, Injury Investigation Reports, and Workplace Injury Inspections at each District location under the general direction of the Risk Manager.

5. The Risk Manager or senior administrator at the ESC is responsible to notify the Division of Occupational Safety and Health *(DOSH)* by telephone in the event of a serious occupational injury or illness, or fatality.

B. *Workers' Compensation Third Party Administrator (TPA)*

1. The TPA is responsible to maintain all workers' compensation claim files on behalf of the District.

   a) Such claim files consist of all relevant records and reports that are required by this procedure including other WCO and treating physician records that are forwarded to the TPA for inclusion into the appropriate case file.

   b) Workers' compensation claim files also consist of Form 5020, *Employer's Report of Occupational Injury or Illness*, Form DWC-1, *Employee Claim for Workers' Compensation Benefits*, Form 5021, *Doctor's First Report of Occupational Injury or Illness*, and all follow-up medical records, vocational rehabilitation records, records of temporary disability payments, and any judicial records, as may be applicable to each case.

2. The specific duties of the TPA are negotiated, contracted, and authorized on behalf of the District by the Director - Business Services Division at the ESC.

C. *Campus Administration Office*

1. At each campus, the Vice President - Administration, or equivalent, is responsible for implementing this procedure and designating a Focal Point Assistant *(FPA)* to maintain the required logs and records on campus *(Step III.A.3, as applicable).*

2. The Facilities Manager or senior campus administrator is responsible to notify the DOSH by telephone in the event of an occupational serious injury or illness, or fatality.

3. The Focal Point Assistant *(FPA)* is responsible to perform the applicable duties specified in Step III.A.3, as applicable, for his/her assigned location.

III. RESPONSIBILITIES *(Continued)*

D. *Onsite Supervisors*

1. **Onsite supervisors** are responsible to provide periodic training to their employees concerning prompt and proper reporting of occupational injuries and illnesses in accordance with this procedure.

2. Supervisors are responsible to ensure that, upon knowledge of a reported occupational injury or illness, the following actions are taken:

   a) The employee receives first aid or medical treatment, as necessary;

   b) Transportation is provided an employee in accordance with Section IV.B.10 of this procedure;

   c) The facility conditions and employee safe work practices are inspected and reviewed in order to prevent further injury or illness to other employees; and

   d) Any human blood is immediately isolated and promptly decontaminated.

3. Supervisors are responsible to complete the Supervisor's Report of Employee Injury or Illness *(Form EH&S RR-03-1)*.

4. Supervisors are responsible to maintain the status of any ill or injured employee, until declared permanent and stationary by the treating physician. Such duties include processing of "disability" and "return-to-work" slips and following up with the employee's status in consultation with, or as requested by, the TPA, WCO, or FPA.

5. **Supervisors shall notify the TPA, WCO, or FPA anytime that a disability period has expired without update**.

E. *Employees*

1. Employees are responsible to comply with all safe work practices, procedures, operating instructions, container labeling information, accident prevention signs and tags posted in the workplace, employee training, employee information notices, and supervisory instructions in order to maintain a working environment that is safe and healthful for all employees.

2. Employees may pre-designate their personal physician to direct initial medical treatment, other than first aid or emergency treatment, for work-related injuries and illnesses *(Statement of Employee's Pre-Designated Physician and Employee Consent, Form EH&S RR-03-5, or equivalent TPA form)*. Employees shall notify the WCO or TPA in writing prior to any work-related injury or illness in order to receive such initial treatment from their personal physicians.

III. RESPONSIBILITIES *(Continued)*

3. Employees are responsible to keep their supervisor informed of any temporary disability status until declared permanent and stationary, whenever possible.

4. All employees shall report occupational illnesses and injuries, as defined in Steps II.I and II.J, immediately, but in no event later than the end of their scheduled shift in accordance with Section IV of this procedure.

IV. REPORTING WORKPLACE INJURY OR ILLNESS

CAUTION: 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.

NOTE: A process model is provided in Appendix N.

A. *General Requirements for All Injuries and Illnesses*

1. Employees shall notify their supervisor of any physical duty restrictions due to non-occupational injury or illness that affects their ability to safely perform their job duties. Such notification is intended to minimize, if not eliminate, the risk of occupational injury that may occur as a result of supervision not being made aware of such restrictions *(e.g., adversely affected by certain prescribed medications, physical therapy treatment, reduced visibility after having been treated by an optometrist, etc.)*.

2. Employees shall report all minor cuts, scratches, abrasions, musculoskeletel strains, or accidents resulting in injury, or any illness, that is directly associated with duties involving their employment, to their onsite supervisor as soon as possible, and in any case prior to the end of their scheduled shift or work day, whenever possible.

3. The onsite supervisor to whom the injured or ill employee reports shall make first aid treatment available to the employee as soon as practical. If the onsite supervisor is not readily available, the College Sheriff shall make first aid available.

4. The employee shall be directed to the College Sheriff to report the injury or illness. At the ESC, the employee shall report to the WCO.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

a) The College Sheriff should document the report on Form EH&S RR-03-4, *Incident / Injury Report*, or equivalent form approved by the Los Angeles County Sheriff's Department *(Appendix A)*. The College Sheriff should forward the white and yellow copies of the report to the FPA.

b) The FPA or WCO, as appropriate, shall document the incident on Cal/OSHA Form 301, *Injury and Illness Incident Report*, or equivalent form *(Form EH&S RR-03-2)* approved by the Director–Business Services, if required *(Appendix B)*.

c) The FPA or WCO, as appropriate, should initiate a Supervisor's Report of Employee Injury or Illness *(Form EH&S RR-03-1)*, or equivalent form *(Appendix C)*, by entering an Incident Number that corresponds to Cal/OSHA Form 301, *Injury and Illness Incident Report*, if required, or equivalent form *(Appendix B)*, and recording the injured or ill employee's name and date and time of injury or illness in the appropriate blocks on the form.

d) Forward the Supervisor's Report to the employee's designated supervisor. If the injured person is a student who is covered by District Workers' Compensation, the FPA or WCO should complete the report by interviewing the responsible instructor, employer, or authorized organization representative in which the incident occurred.

5. If the injury involved the presence of human blood or other bodily fluids containing human blood, the onsite supervisor shall ensure that the worksite location and traffic route is decontaminated in accordance with EH&S EC-01, *Bloodborne Pathogens Exposure Control Plan*.

a) To avoid the risk of exposure of human blood to other employees or to the public, the injured employee should assist in the decontamination of their own blood or bodily fluids, whenever possible and appropriate to the type and nature of the incident.

b) Any employee who provides emergency response in circumstances involving the presence of human blood shall be provided all treatment and follow-up actions in accordance with the Bloodborne Pathogens Exposure Control Plan and Title 8, California Code of Regulations, Section 5193 *(Appendix D - see also Steps IV.A.6 and IV.A.7 below)*.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

6. Upon receipt of the Supervisor's Report of Employee Injury or Illness *(Appendix C or equivalent)* from the FPA or WCO, the onsite supervisor shall interview the injured or ill employee before completing the administrative information section and document any first aid treatment rendered. The onsite supervisor shall include information listing incident witnesses and first-aid responder exposure to human blood or other potentially infectious materials, if any.

   a) The onsite supervisor is responsible to perform a workplace injury inspection to ensure that no concealed hazards exist that could cause harm to other employees.

   b) Any facility inspection observations, deficiencies, or violations found relevant to the employee injury or illness should be identified and documented, including any corrective actions taken, on the report.

   c) The completed report shall be returned to the FPA or WCO, as appropriate, within two- (2) workdays.

   d) The FPA should return the completed and reviewed Supervisor's Report to the WCO within one- (1) workday.

   e) The WCO shall forward the Supervisor's Report of Employee Injury or Illness *(Appendix C)*, or equivalent form, to the TPA for any reported injury or illness that results in a recordable case within two- (2) workdays.

7. The FPA or WCO shall initiate Form 5020, *Employer's Report of Occupational Injury or Illness (Appendix E)*, and provide DWC Form 1, *Employee's Claim for Workers' Compensation Benefits (Appendix F)* to any employee who renders emergency response to an injured or ill employee in which there exists the presence of human blood in accordance with EH&S EC-01, *Bloodborne Pathogens Exposure Control Plan.*

   NOTE: Section IV.B of this procedure provides instructions for initiating and processing Form 5020 and DWC Form 1.

   a) Such emergency responders shall be provided any appropriate medical and related follow-up treatment.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

b) Print or type "BLOODBORNE PATHOGENS EXPOSURE INCIDENT" on line 29 of Form 5020.

c) The WCO shall initiate Form EH&S EC-01-3, *Bloodborne Pathogens Exposure Incident Log (Appendix D)*, upon receipt of Form 5020 listing "Bloodborne Pathogens Exposure Incidents" on behalf of the District.

CAUTION: Failure on the part of an employee, the employee's designated representative, a student worker, or in the case of death a dependent or the dependent's representative, to report workplace injury or illness within thirty- (30) days may result in certain limitations of proceedings pursuant to Labor Code, Section 5400, et seq.

8. If an employee fails to report the work-related injury or illness through the onsite supervisor, and instead reports directly to the College Sheriff or WCO, the Police or WCO should process the required information as much as possible and then shall direct the employee to make the required report to their onsite supervisor in accordance with this Section *(IV.A)*.

9. If an employee perceives that, as a result of medical treatment from a personal physician an occupational injury or illness has occurred, the employee shall immediately notify his/her supervisor, College Sheriff, or WCO, and make the required report in accordance with this Section *(IV.A)*.

10. If a student worker or other student covered by District Workers' Compensation becomes ill or injured arising out of and during the course of covered activities, the student worker shall notify the responsible instructor, employer, or authorized organization representative and the College Sheriff, FPA, or WCO, as appropriate.

11. If any supervisor, manager, or administrator becomes knowledgeable of an unreported occupational injury or illness, immediately notify the Campus FPA or District WCO.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

B. *Recordable Cases*

CAUTION: If the employee does not report in person to the College Sheriff or WCO, the claim form must be mailed to the employee's listed home of residence within twenty-four- (24) hours of knowledge of the reported injury or illness. If such is the case, notify the FPA or WCO to ensure the required mailing occurs.

NOTE: The following steps are required in addition to all of the pertinent requirements of Section IV.A.

1. The College Sheriff or WCO, as appropriate, **shall provide** the injured or ill employee with **DWC Form 1**, *Employee's Claim for Workers' Compensation Benefits (Appendix F)*.

   a) If the employee opts to submit a claim for workers' compensation benefits, the employee shall complete the blocks listed in the employee's section of the form.

   b) The employee shall return the claim form to his/her supervisor, the FPA, or WCO, as appropriate.

   c) The supervisor or FPA/WCO shall complete the blocks listed in the employer's section of the form.

      (i) Any supervisor, manager, or administrator may sign for employer representative.

      (ii) Return the completed "pink" employee copy to the injured/ill party.

      (iii) Return the remaining copies to the WCO.

2. The FPA or WCO **shall initiate Form 5020**, *Employer's Report of Occupational Injury or Illness (Appendix E),* or equivalent. Complete all required blocks and sections.

   a) The FPA or WCO shall include his/her printed name, signature, title, and date in the blocks indicated at the bottom of Form 5020.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

b) In the absence of the FPA or WCO, the injured / ill person's supervisor or higher-level administrator shall sign Form 5020.

3. At each campus the FPA shall immediately notify the WCO and TPA that Form 5020 has been generated and is enroute to the WCO. Substantial compliance with this step is attained by electronic email transmission or FAX copy to the WCO and TPA **or** telephone directly for special instructions.

4. The FPA shall send Form 5020 *(original and first copy)* to the WCO within two- (2) workdays of the reported injury or illness via Courier Mail or hand-deliver. Retain the second copy for campus records.

5. The WCO shall review Form 5020 for completeness and then forward the original to the TPA for inclusion in the appropriate case file. The remaining copy is retained for District records.

6. The FPA or WCO, as appropriate, shall complete Sections A through F of Cal/OSHA Form 300, *Log of Work-Related Injuries and Illnesses (Appendix G)*, if required.

7. Within seven- (7) calendar days of the employee reported injury or illness, FPA or WCO, as appropriate, shall complete Sections G through M of Cal/OSHA Form 300, *Log of Work-Related Injuries and Illnesses (Appendix G)*, if required and as appropriate to the incident.

8. The FPA or WCO, as appropriate, is responsible for updating Sections G through M of Cal/OSHA Form 300 on a weekly basis until the injury or illness is resolved or until the TPA closes the case.

9. If treatment is needed beyond first aid which is available at the District location, the onsite supervisor, College Sheriff, or WCO, as appropriate, should provide the injured / ill person with Form EH&S RR-03-3, *Referral For Treatment of Occupational Injury or Illness*, or equivalent form *(Appendix H)*.

NOTE: If the employee has pre-designated their personal physician to treat work-related injuries or illnesses by submitting Form EH&S RR-03-5, *Statement of Employee's Pre-Designated Physician and Employee Consent*, or equivalent TPA form *(Appendix I)*, the employee may opt to report to that physician for treatment. Both the physician and the employee must complete their respective sections to be accepted by the District.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

10. **Transportation**. Normally, the injured / ill employee shall self-transport for medical treatment. If the employee cannot self-transport to the pre-designated physician or District physician for treatment, the supervisor should contact an ambulance to transport the injured/ill employee. The supervisor may exercise personal discretion to transport the employee in a personal vehicle as follows:

    a) The supervisor is under no obligation to transport the employee;

    b) The supervisor must have automobile liability insurance coverage with limits established by state law;

    c) The supervisor's personal automobile insurance will be primary and excess of any applicable District insurance; and

    d) The supervisor may only transport the employee to a District physician.

    NOTE: The District only accepts responsibility for transporting employees for medical treatment of work-related injuries / illnesses to a contracted District physician.

C. *Serious Injury or Illness*

CAUTION: Preservation of human life and public / employee health and safety take priority over all other procedures and protocols. **In the case of serious injury or illness, provide any first aid consistent with your qualifications and level of training, perform any required local area evacuations, and immediately notify College Sheriff**. Review all applicable steps of this procedure as time later permits.

NOTE: The following steps are required in addition to all pertinent requirements of Sections IV.A and IV.B.

1. The injured employee shall immediately be provided with emergency treatment, but not to the extent as to cause serious injury or endanger the lives of emergency responders, other employees, or the general public.

2. Emergency telephone numbers are provided in Appendix J of this procedure.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

3. **Division of Occupational Safety and Health (DOSH) Notification.** In the event of a serious injury or illness, or death, a telephone call shall be made to DOSH immediately *(i.e., as soon as possible),* but no later than eight- (8) hours after it is known that the event occurred *(8CCR§342, Labor Code §6302 and §6313)*.

   a) Serious injury or illness is defined to require inpatient hospitalization for a period in excess of twenty-four- (24) hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

   b) Serious injury or illness resulting from traffic accidents or penal code violations are not normally included towards mandatory notification consideration, except for violations of Penal Code §385, *(Tools, machinery, cranes, power shovels, etc., near high voltage overhead conductors; offense; posting notices; exceptions)*.

      NOTE: Although most all injuries and illnesses resulting from Penal Code violations are exempted from mandatory notification to DOSH, there are certain exceptions as may apply in the case of serious injury during a workplace violence event *(EH&S EP-02, Workplace Violence Prevention Control Plan).* Therefore, it is recommended that any death or serious injury or illness be reported immediately to DOSH.

   c) If the serious injury is as a result of a workplace violence event, observe the procedures and precautions provided in EH&S EP-02, *Workplace Violence Prevention Control Plan*, for employee conduct within a crime scene.

   d) The required information shall be collected and made available at the time the telephone call is made by the Facilities Manager or a senior administrator.

   e) The information should be documented using the Telephone Notification to the Division of Occupational Safety and Health Checklist *(Appendix K)*.

   f) Document the date, time, location from, and manager/administrator who made the required telephone notification to DOSH.

IV. REPORTING WORKPLACE INJURY OR ILLNESS *(Continued)*

4. **Division of Workers' Compensation (DWC) Notification.**

In the event of an employee death due to occupational injury or illness, the Administrative Director of the DWC shall be notified in writing in accordance with Title 8, California Code of Regulations, Section 9900.

a) The WCO is responsible to prepare this notification.

b) The notification shall be made using DIA Form 510, *Notice of Employee Death (Appendix L),* or equivalent form approved by the Director - Business Services at the ESC.

c) The Risk Manager, Director - Business Services, General Counsel, Vice Chancellor - Operations, Vice Chancellor – Human Resources, or Chancellor are authorized to sign DIA Form 510 on behalf of the District.

d) Notification shall be made within sixty- (60) days of the District's knowledge of the employee's death.

V. EMPLOYEE INFORMATION

A. *Written and Posted Notices to Employees*

1. **Every employee shall be advised in writing**, either at the time of hire or no later than the end of the first pay period, of information concerning the rights, benefits and obligations under workers' compensation law. The notice shall include the following information:

a) An explanation of the extent and scope of coverage provided by the workers' compensation law;

b) An explanation of the employee's rights to medical care and to select and change the treating physician;

c) An explanation of the injured employee's rights to indemnity payments for disability or death and the availability of vocational rehabilitation services;

d) The procedures for reporting accidents and injuries to the District; and

e) Where further information may be obtained, including an explanation of services available from an Information and Assistance Officer.

V. EMPLOYEE INFORMATION *(Continued)*

2. **At every District location a notice shall be posted** in a conspicuous location frequented by employees. The notice shall have the following information:

   a) Advice to employees that all injuries should be reported and to whom job accidents and injuries are reported;

   b) Advice concerning employees' rights and medical care and to select or change the treating physician;

   c) Advice concerning the employees' entitlements to indemnity payments and vocational rehabilitation services;

   d) Advice that the District may not be responsible for compensation because of an injury due to the employee's voluntary participation in any off-duty recreational, social, or athletic activity that is not a part of the employee's work-related duties;

   e) Whether the District is self-insured for workers' compensation or, if not, the name of the current insurer, and the location of the person or office responsible for claims adjustment;

   f) The street address and telephone number of the nearest Information and Assistance Officer of the Department of Industrial Relations - Division of Workers' Compensation;

   g) Emergency telephone numbers for physician, hospital, ambulance, police and firefighting services; and

   h) A copy of Cal/OSHA Form 300A, *Annual Summary of Work-Related Injuries and Illnesses (Appendix G)*, shall be posted in the month of February for the previous calendar year, if required.

B. *TPA Information to Injured / Ill Employees (Appendix M))*

1. Within five- (5) days of notice or knowledge of an employee occupational injury or illness, the injured employee shall be advised of the compensation to which he or she may be entitled and the rights, benefits, and obligations under the workers' compensation law.

2. The information shall be written and available in English and Spanish.

3. The following information shall be provided:

V. EMPLOYEE INFORMATION *(Continued)*

a) An explanation of an injured employee's rights to medical care and to select and change the treating physician;

b) An explanation of an injured employee's rights to indemnity payments for disability or death, including information of the amount and frequency of such payments;

c) An explanation of the nature and availability of vocational rehabilitation services;

d) An explanation of the employee's protections against discrimination because of a work injury;

e) An explanation of the procedures for claiming compensation, time limits for filing a claim, and methods to resolve disputes, including the employee's right to consult an Information and Assistance Officer or an attorney; and

f) Where further information may be obtained, including an explanation of services available from an Information and Assistance Officer.

VI. RECORDKEEPING

NOTE: The District is exempt from maintaining records of work-related injuries and illnesses in accordance with Title 8, California Code of Regulations, Section 14300.2. However, the Risk Manager, Director of Business Services, Senior Vice Chancellor, or Chancellor may require a District location to maintain such records in accordance with this procedure. The Cal/OSHA rule states that such records may be required upon written request from OSHA, the Bureau of Labor and Statistics, or other state agency acting under their authority.

A. ***All occupational injury and illness records required by this procedure revision and previously required records*** **shall be preserved and maintained for at least five- (5) years** beyond the year in which the injury or illness occurred or was reported, whichever is longer, unless otherwise excepted in accordance with Step VI.B.

B. ***The Log of Work-Related Injuries and Illnesses, Injury and Illness Incident Report, and the Annual Summary of Work-Related Injuries and Illnesses, if required,*** shall be made available to employees, designated employee representatives, and to DOSH or other State regulatory agency for examination and copying in accordance with Title 8, California Code of Regulations, Section 14308, *Access to Records.*

C. ***Occupational injury and illness records*** shall be sent to the TPA for the respective case files, as appropriate. Such records include:

1. **Supervisor's Report of Employee Injury or Illness** *(Appendix C)*; if completed for non-recordable cases, then the record may be discarded after it is no longer needed. Send recordable case reports to the TPA via the WCO.

VI. RECORDKEEPING *(Continued)*

2. **Injury and Illness Incident Report [Cal/OSHA Form 301 *(Appendix B)*]**; preserve and maintain this record with the FPA or WCO, if required.

3. **Employee Claim for Workers' Compensation Benefits** DWC Form 1 *(Appendix F)*; send this form to the WCO.

4. **Referral for Treatment of Occupational Injuries and Illnesses** *(Appendix H)*; the employee should deliver this form to the physician.

5. **Employer's Report of Occupational Injury or Illness** *(Appendix E)*; send this report to the WCO.

6. **Log of Work-Related Injuries and Illnesses [Cal/OSHA Form 300 *(Appendix G)*]**; preserve and maintain this log at the District location where the log is generated, if required.

7. **Annual Summary of Work-Related Injuries and Illnesses [Cal/OSHA Form 300A *(Appendix G)*]**; preserve and maintain this log at the District location where the log is generated, if required.

   a) **A copy of the completed previous year's log should be sent to the WCO** in the month of January of the new calendar year, if generated.

   b) T**he FPA or WCO shall post a copy of the Annual Summary** on administrative bulletin boards in the month of February for the previous year.

8. **Telephone Notification to the Division of Occupational Safety and Health Checklist** *(Appendix K)*; the original completed notification form, if used, should be submitted to the Vice President - Administration, or equivalent, for review and filing. At the ESC, the completed form should be submitted to the Director - Business Services for review and filing. Telephone notification records need not be retained for any specific time period.

9. **Notice of Employee Death** *(Appendix L)*; send a copy of the completed notice to the Vice Chancellor – Human Resources for inclusion into the employee's occupational medical record. Send a copy to the TPA for filing.

10. **Bloodborne Pathogens Incident Log** *(Appendix D)*; copy completed logs to the TPA for information only. The original should be retained at the WCO for at least five- (5) years beyond the year in which the log is generated.

APPENDIX A

LOS ANGELES COMMUNITY COLLEGE DISTRICT INCIDENT / INJURY REPORT

<table>
<tr><td colspan="4">Los Angeles Community Colleges
770 Wilshire Boulevard
Los Angeles, CA 90017
In partnership with the
Los Angeles County Sheriff's
Department</td><td colspan="2">Date and Time Reported to Sheriff's Department</td><td>Incident No.</td></tr>
<tr><td colspan="4"></td><td colspan="2">Name of College Campus</td><td>Date and Time Incident Occurred</td></tr>
<tr><td colspan="4">Party's Name (Last, First, Middle)</td><td colspan="3">Specify the Location on the Campus Where Incident Occurred</td></tr>
<tr><td colspan="4">Party's Home Address</td><td colspan="2">Party's Home Telephone No.</td><td>Type of Injury (Industrial, Accident)</td></tr>
<tr><td>Sex</td><td>Race</td><td>Date of Birth</td><td>Age</td><td colspan="2">Party's Employee Number</td><td>Extent of Injury (Minor or Serious)</td></tr>
<tr><td>Height</td><td>Weight</td><td>Color Hair</td><td>Color Eyes</td><td colspan="2">Party's Driver's License No.</td><td>Transported to:</td></tr>
<tr><td colspan="2">Supervisor's / Instructor's Name</td><td colspan="2">Supervisor's Telephone No.</td><td colspan="2">Fire Company</td><td>Transported By:</td></tr>
<tr><td colspan="2">Supervisor / Instructor Notified?
Yes No</td><td colspan="2">Date and Time Notified</td><td colspan="2">__ Employee __ Student
__ Visitor __ Student Worker</td><td>_____ Date & Time
DWC-1 Form Issued
_____ Date Medical Referral Issued</td></tr>
<tr><td colspan="2">Witness (Last, First, Middle)</td><td colspan="2">Date of Birth</td><td>Residence Address</td><td>Residence Telephone</td><td>Business Telephone</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">(1) Party's Statement</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7">(2) Physical Observations</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7">(3) Additional Information</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="2">Reporting Officer</td><td colspan="2">Approving Supervisor</td><td>Person Reporting Incident (Print)</td><td colspan="2">Person Reporting (Signature)</td></tr>
<tr><td colspan="2">Date and Time Received</td><td colspan="2">Division - Clerk</td><td colspan="3">Signature</td></tr>
</table>

REFERENCE: LACCD EH&S RR-03

LACCD EH&S RR-03-4 Rev. 1 06/01

White Copy - District Risk Management Office
Yellow Copy - College
Pink Copy - Sheriff

APPENDIX B

INJURY AND ILLNESS INCIDENT REPORT (Cal/OSHA Form 301)

Cal/OSHA Form 301 **Appendix C**
Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.
See CCR Title 8 14300.29(b)(6)-(10)

Department of Industrial Relations
Division of Occupational Safety & Health

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with *Log of Work-Related Injuries and Illnesses* and the accompanying *Annual Summary*, these forms help the employer and Cal/OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the instructions and information asked for on this form.

According to CCR Title 8 Section 14300.33 Cal/OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____)_____-_____ **Date** ____/ ____/ ____

Information about the employee

1) **Full name** _____

2) **Street** _____

City _____ **State** _____ **ZIP** _____

3) **Date of birth** _____/ _____/ _____

4) **Date hired** _____/ _____/ _____

5) ☐ **Male**
☐ **Female**

Information about the physician or other health care professional

6) **Name of physician or other health care professional** _____

_____

7) **If treatment was given away from the worksite, where was it given?**

Facility _____

Street _____

City _____ **State** _____ **ZIP** _____

8) **Was employee treated in an emergency room?**
☐ **Yes**
☐ **No**

9) **Was employee hospitalized overnight as an in-patient?**
☐ **Yes**
☐ **No**

Information about the case

10) **Case number from the *Log*** _____ *(Transfer the case number from the Log after you record the case.)*

11) **Date of injury or illness** _____/ _____/ _____

12) **Time employee began work** _____ **AM / PM**

13) **Time of event** _____ **AM / PM** ☐ **Check if time cannot be determined**

14) *What was the employee doing just before the incident occurred?* **Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."**

15) *What happened?* **Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."**

16) *What was the injury or illness?* **Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."**

17) *What object or substance directly harmed the employee? Examples:* **"concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.***

18) *If the employee died, when did death occur?* **Date of death** _____/ _____/ _____

APPENDIX C

REFERENCES: 8CCR§3203
EH&S RR-03

Incident No. *(From Supplementary Record)*	
TPA Case No. *(From TPA Files)*	

(From FPA Supplementary Log)

LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS

Page 1 of 2

NOTE: *This form should be completed and sent to the District Workers' Compensation Office within two- (2) working days of the reported injury.*

SECTION I: ADMINISTRATIVE

COLLEGE		**DEPT. / DIV.**	
EMPLOYEE NAME		**POSITION CLASSIFICATION**	
DATE AND TIME OF INJURY OR ILLNESS		**DATE AND TIME SUPERVISOR KNEW OF EMPLOYEE INJURY OR ILLNESS**	
INCIDENT LOCATION		**NATURE OF INJURY**	

SECTION II: EMERGENCY TREATMENT

TYPE OF TREATMENT RENDERED (✓)	NAME(S) OF FIRST AID RESPONDERS, MEDICAL PROFESSIONALS, OR EMERGENCY TREATMENT PROVIDERS	BLOODBORNE PATHOGENS EXPOSURE INCIDENT? (✓) ☐ NO ☐ YES *IF YES, SPECIFY ROUTE OF ENTRY BELOW*	NAME(S) OF WITNESSES TO THE OCCUPATIONAL INJURY OR ILLNESS
☐ **FIRST AID (SELF ADMIN)**		☐ **INGESTION**	
☐ **FIRST AID by EMPLOYEES**		☐ **INHALATION**	
☐ **FIRST AID by PHYSICIAN or NURSE**		☐ **PARENTERAL**	
☐ **EMERGENCY TREATMENT**		☐ **ABSORPTION**	

SECTION III: DESCRIPTION OF HOW THE EMPLOYEE WAS INJURED *(Supervisor to discuss with the employee)*

LACCD EH&S RR-03-1 Rev. 5 05/01

APPENDIX C

LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS

Page 2 of 2

SECTION IV: FACILITY INSPECTION OBSERVATIONS

SECTION V: DID EMPLOYEE FOLLOW SAFE WORK PRACTICES?

SECTION VI: RECOMMENDED ACTION OR ACTIONS TO BE TAKEN TO PREVENT RECURRENCE

☐ **EMPLOYEE TRAINING** ☐ **PROCEDURE REVISION** ☐ **MAINTENANCE SERVICE REQUEST** ☐ **SIGNS, TAGS, LABELS**

SECTION VII: REVIEW AND APPROVAL

SUPERVISOR *(Print Name)*		**SUPERVISOR** *(Signature / Date)*	
ADMINISTRATOR *(Print Name)*		**ADMINISTRATOR** *(Signature / Date)*	

REFERENCES: 8CCR§3203
EH&S RR-03

LACCD EH&S RR-03-1 Rev. 5 05/01

APPENDIX D
LOS ANGELES COMMUNITY COLLEGE DISTRICT
BLOODBORNE PATHOGENS EXPOSURE INCIDENT LOG

(A) Code Name	(B) Location	(C) HBV Vaccination Series Date	(D) Exposure Incident Date/Time	(E) Form 5020 Complete? (Y/N)	(F) Medical Authorization Form Completed? (Y/N)	(G) Injury Report Completed? (Y/N)	(H) Medical Evaluation Made Available (Date)	(I) Source Individual's Blood Tested? (Y/N) or (N/A)
1.								
2.								
3.								

(J) Exposed Employee's Blood Tested? (Y/N)	(K) Post-Exposure Treatment Recommended? (Y/N)	(L) Post-Exposure Counseling Made Available? (Date)	(M) Evaluation of Reported Illness Completed? (Y/N) or (N/A)	(N) Health Care Professional's Written Opinion Received? (Date/Time)	(O) Employee receipt of Written Opinion (Date/Time)	(P) Follow-up Program Recommended? (Y/N)	(Q) Estimated Completion Date of Follow-up Program	(R) Actual Completion Date of Follow-up Program
1.								
2.								
3.								

REFERENCES: 8CCR§5193
EH&S EC-01

NOTES:

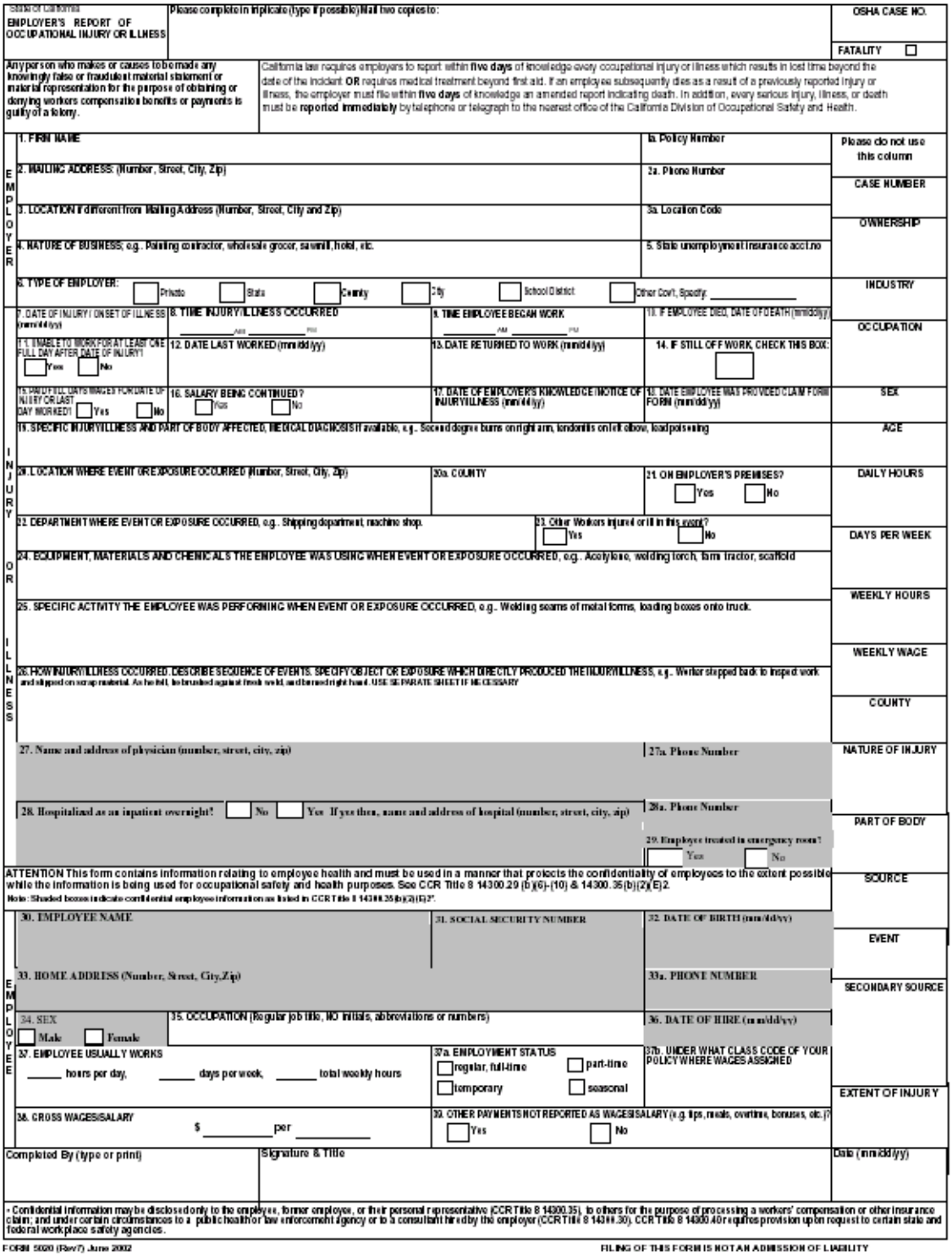
1. Table Entries

A. Personal identifiers may not be used. Link name with incident number (College Initials, YR.-01, -02, -03, ...).
B. Campus name, District Office, Building, etc.
C. Date employee completed pre-exposure vaccination series, or "N/A" for "not applicable".
D. Date and time of bloodborne pathogens exposure incident.
E. Completion includes copy given to employee. Line 29, "BLOODBORNE PATHOGENS EXPOSURE INCIDENT".
F. Completion includes form given to employee.
G. Injury Report includes names of all first aid providers who rendered assistance, description of incident, date, time, and whether blood or potentially infectious materials were present. Include route(s) of exposure and exposed employee's duties as they relate to the incident. Send copy to the health care provider.
H. Date and time employee scheduled to receive medical evaluation. The evaluation follow-up report must contain information required per Step VII.C.1.(a) through (f) of EH&S EC-01, Bloodborne Pathogens Exposure Control Plan.
I. Consent is required or "N/A" for "not available".
J. Consent is required.
K. Post-exposure treatment need not occur at the initial evaluating health care facility.
L. Post-exposure counseling need not occur at the initial evaluating health care facility.
M. Evaluation of reported illnesses associated with this exposure incident or "N/R" for "none reported".
N. Copy of written opinion must be received within 15 days of service performed by the evaluating health care facility.
O. Date given in person (or mailed) to the employee.
P. Indicate whether a follow-up program is recommended. Include the date the program is scheduled to begin.
Q. Enter the estimated completion date of the recommended follow-up program.
R. Enter the actual completion date of the follow-up program.

2. Verification with Medical Records is recommended upon closure of each line item. Cal/OSHA Form 300 Log Entry for exposure incident medical treatment, IF REQUIRED.

LACCD EH&S EC-01-3 Rev 4 01/02

APPENDIX E
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS



State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** 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 **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME — 1a. Policy Number — Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip) — 2a. Phone Number — CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip) — 3a. Location Code — OWNERSHIP
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. State unemployment insurance acct no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____ — INDUSTRY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy) — 8. TIME INJURY/ILLNESS OCCURRED _____AM _____PM — 9. TIME EMPLOYEE BEGAN WORK _____AM _____PM — 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy) — OCCUPATION
11. ENABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No — 12. DATE LAST WORKED (mm/dd/yy) — 13. DATE RETURNED TO WORK (mm/dd/yy) — 14. IF STILL OFF WORK, CHECK THIS BOX: ☐ — SEX
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No — 16. SALARY BEING CONTINUED? ☐ Yes ☐ No — 17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy) — 18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy) — AGE
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED; MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning — DAILY HOURS
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) — 20a. COUNTY — 21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No — DAYS PER WEEK
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop. — 23. Other Workers Injured or Ill in this event? ☐ Yes ☐ No — WEEKLY HOURS
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold — WEEKLY WAGE
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck. — COUNTY
26. 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 — NATURE OF INJURY
27. Name and address of physician (number, street, city, zip) — 27a. Phone Number — PART OF BODY
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip) — 28a. Phone Number — 29. Employee treated in emergency room? ☐ Yes ☐ No — SOURCE

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35 (b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*. — EVENT

EMPLOYEE

30. EMPLOYEE NAME — 31. SOCIAL SECURITY NUMBER — 32. DATE OF BIRTH (mm/dd/yy) — SECONDARY SOURCE
33. HOME ADDRESS (Number, Street, City, Zip) — 33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female — 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) — 36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours — 37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal — 37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED — EXTENT OF INJURY
38. GROSS WAGES/SALARY $ _____ per _____ — 39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print) — Signature & Title — Date (mm/dd/yy)

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002 — FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

APPENDIX F

Page 1 of 3

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

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

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be 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 call the Division of Workers' Compensation 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 back 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.

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado 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, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401**. En la parte de atrás 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 a proposito 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 ocurió 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 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.* _____ 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, ó 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

Original (Employer's Copy)
DWC Form 1 (REV. 1/94)

ORIGINAL (Copia del Empleador)
DWC Forma 1 (REV. 1/94)

APPENDIX F

Page 2 of 3

WORKERS' COMPENSATION BENEFITS

Medical Care. All medical care for your work injury or illness will be paid for by your employer or employer's insurance company. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your employer or employer's insurance company will pay the cost directly so you should never see a bill.

Payment for Lost Wages. If you can't work because of a job injury or illness, you will receive "temporary disability" benefit payments. The payments will stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, up to a maximum set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized or cannot work for more than 14 days.

Payment for Permanent Disability. If the injury or illness results in a permanent handicap, permanent disability benefit payments will be paid after recovery. The amount of benefits will depend on the type of injury, and your age and occupation.

Rehabilitation. If the injury or illness prevents you from returning to the same type of job, you may qualify for "vocational rehabilitation benefits". These benefits include services to help you get back to work. If you qualify for vocational rehabilitation, the costs will be paid by your employer or employer's insurance company, up to a maximum set by state law.

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

Disclosure of Medical Records. After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that people usually expect for medical records. Records of all medical treatment you have received, even for injuries or illnesses that are not caused by your work, may be read by a variety of people. If you do not agree to voluntarily release medical records, they can be "subpoenaed" and ordered to be released. A workers' compensation judge may "seal" (keep private) certain medical records if the worker requests privacy.

For More Information. If you need help filling out this form, or if you have questions about workers' compensation benefits, please call an Information and Assistance Officer in the local office of the Division of Workers' Compensation. You may hear recorded information and a list of local offices by calling this toll free number: **1-800-736-7401.** This is a free service of the State of California. You may also consult an attorney.

BENEFICIOS DE COMPENSACIÓN AL TRABAJADOR

Cuidado Médico. *Todo el cuidado médico por su lesión o enfermedad causada en el trabajo será pagado por su empleador/patrón o su compañía de seguros. Los beneficios médicos pueden incluir tratamiento por un doctor, servicios de hospital, fisioterapia, análisis de laboratorio, rayos-x, y medicamentos. Su empleador o la compañía de seguros de su empleador pagará directamente el costo, así Ud. nunca tendrá que ver una cuenta.*

Pago por Pérdida de Sueldos. *Si Ud. no puede trabajar debido a una enfermedad o lesión causada en el trabajo, Ud. recibirá pagos de beneficio de "incapacidad temporal". Los pagos se detendrán cuando su médico indique que Ud. puede volver a su trabajo. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos-tercios del promedio de su pago semanal, hasta un máximo asignado por la ley del estado. No se efectúa pago por los tres primeros días que Ud. esta incapacitado a menos que Ud. este hospitalizado o no pueda trabajar por mas de 14 días.*

Pagos por Incapacidad Permanente. *Si los resultados de la lesión o enfermedad producen un impedimento o incapacidad permanente, se efectuarán pagos de incapacidad permanente después de la recuperación.*

Rehabilitación. *Si la lesión o enfermedad le impide a Ud. volver al mismo trabajo, puede ser que Ud. califique para los "beneficios de rehabilitación vocacional". Estos beneficios incluyen servicios para ayudarlo a que Ud. vuelva a trabajar. Si Ud califica para rehabilitación vocational, los costos serán pagados por su empleador o su compañía de seguros, hasta un maximo asignado por la ley del estado.*

Beneficios de Muerte. *Si la lesión o enfermedad resulta en muerte, los pagos pueden ser efectuados a parientes o a miembros de la familia quienes dependen financieramente del trabajador.*

Revelación de Expedientes Médicos. *Después de que Ud. efectúa un reclamo para beneficios de compensación del trabajador sus expedientes médicos no tendrán la misma privacidad que la gente por lo general espera de los expedientes médicos. Un expediente de todos los tratamientos médicos que Ud. haya recibido, inclusive de lesiones o enfermedades que no hayan sido causadas por su trabajo, pueden ser leídas por distintas personas. Si Ud. no esta de acuerdo a entregar voluntariamente los archivos médicos, pueden ser ordenados en un "comparendo" (orden judicial) y que ordenan su entrega. Un juez de compensaciones al trabajador, puede "cerrar" (mantenidos en privado) ciertos expedientes médicos si el trabajador solicita privacidad.*

Información y Asistencia. *Si Ud. necesita ayuda para completar esta forma, o si Ud. tiene preguntas relacionadas con sus beneficios, por favor póngase en contacto con un Oficial de Información y Asistencia en la oficina local de la División de Compensación al Trabajador. Ud. puede escuchar información grabada y una lista de las oficinas locales llamando gratis al número: 1-800-736-7401. Este es un servicio gratis del Estado de California. Ud. también puede consultar a un abogado.*

APPENDIX F
Page 3 of 3

LOS ANGELES COMMUNITY COLLEGE DISTRICT
DWC-1 FORM SUPPLEMENTARY NOTICE

OPTIONAL

NOTE: The below notice may be attached to Form DWC-1 in order to assist employees with form completion. Instructions are provided on the form itself.

NOTICE TO EMPLOYEES

IN ORDER TO FILE A WORKERS' COMPENSATION CLAIM YOU MUST

1. **Complete the "Employee" section of this DWC-1 form**
2. **Keep the copy marked "Employee's Temporary Receipt"**
3. **Return the completed form to:**

_____

Upon receipt of the completed form, the College will complete the "Employer" section of the form and give you the pink copy marked "Employee's Copy" as a receipt.

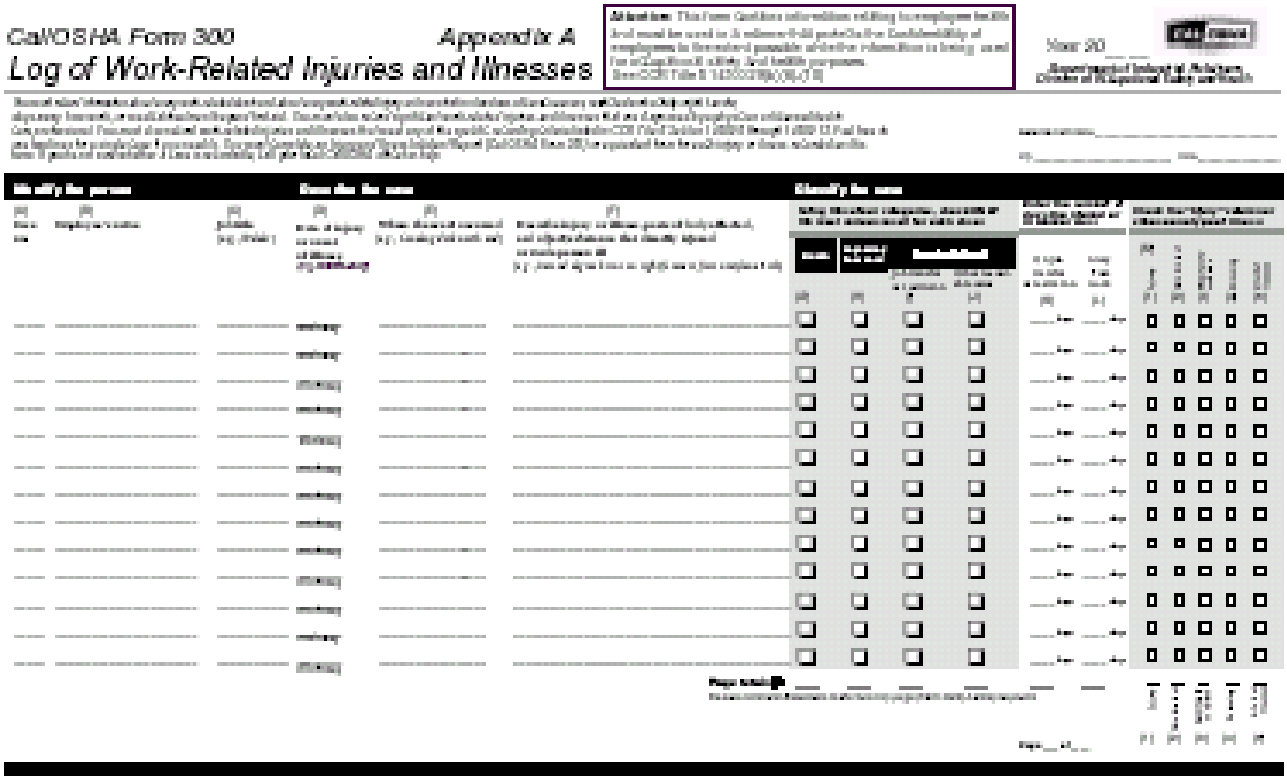
If you have any questions regarding the completion of this form, you may contact the Division of Workers' Compensation at 1-800-736-7401, or you may call:

_____ at (_____) _____ - _____ .

LACCD EH&S RR-03-6 Rev. 0 05/01 **REFERENCE: EH&S RR-03**

APPENDIX G
Page 1 of 2

LOG OF WORK-RELATED INJURIES AND ILLNESSES (Cal/OSHA Form 300)



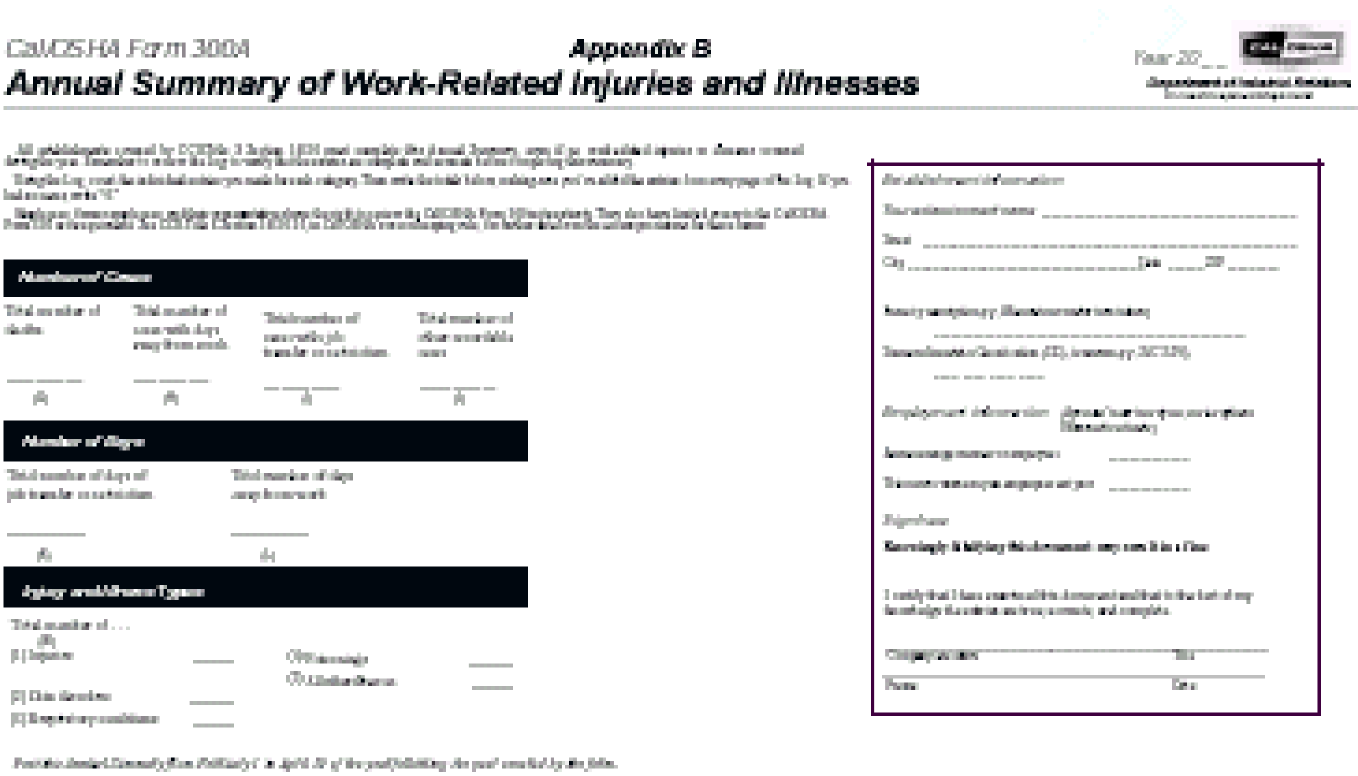
CalOSHA Form 300 Appendix A
Log of Work-Related Injuries and Illnesses

Year 20__

APPENDIX G

Page 2 of 2

ANNUAL SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES (Cal/OSHA Form 300A)



APPENDIX H
Page 1 of 2

REFERENCES: **EH&S RR-03**
8 CCR §9780 et seq

LOS ANGELES COMMUNITY COLLEGE DISTRICT
REFERRAL FOR TREATMENT OF OCCUPATIONAL INJURY OR ILLNESS

Page 1 of 2

NOTE: *This form should be given to the employee and presented to the treating physician.*

SECTION I: ADMINISTRATIVE

COLLEGE		**DEPT. / DIV.**	
EMPLOYEE NAME		**CLASSIFICATION** _____ SOCIAL SECURITY NO	_____
DATE AND TIME OF INJURY OR ILLNESS		**DATE AND TIME OF THIS REFERRAL**	
INCIDENT LOCATION		**NATURE OF INJURY**	

SECTION II: AUTHORIZED HEALTH CARE PROVIDERS

EDUCATIONAL SERVICES CENTER	**SAMARITAN HEALTH CENTER** **637 SOUTH LUCAS AVE.** **LOS ANGELES, CA 90017** **(213) 977-4111**	**LOS ANGELES PIERCE COLLEGE**	**WEST HILLS HOSPITAL MEDICAL CENTER** **7300 MEDICAL CENTER DRIVE** **WEST HILLS, CA 91307** **(818) 340-0977**
LOS ANGELES CITY COLLEGE	**CITIZEN MEDICAL GROUP** **1300 NORTH LA BREA** **LOS ANGELES, CA 90028** **(213) 464-1336**	**LOS ANGELES SOUTHWEST COLLEGE**	**RFK MEDICAL** **4500 WEST 116TH ST** **HAWTHORNE, CA 90250** **(213) 970-0653**
EAST LOS ANGELES COLLEGE	**ALHAMBRA HOSPITAL** **100 SOUTH RAYMOND** **ALHAMBRA, CA 90801** **(626) 458-4764**	**LOS ANGELES TRADE-TECHNICAL COLLEGE**	**SAMARITAN HEALTH CENTER** **637 SOUTH LUCAS AVE.** **LOS ANGELES, CA 90017** **(213) 977-4111**
LOS ANGELES HARBOR COLLEGE	**IMMEDIATE MEDICAL CARE CENTER** **26516 CRENSHAW BLVD** **ROLLING HILLS, CA 90274** **(310) 541-7911** **WESTERN MEDICAL GROUP** **21081 SOUTH WESTERN, STE. 150** **TORRANCE, CA 90501** **(310) 782-3333**	**LOS ANGELES VALLEY COLLEGE**	**SHERMAN OAKS COMMUNITY HOSPITAL** **4929 VAN NUYS BLVD** **SHERMAN OAKS, CA 91403** **(818) 981-7111** **U.S. HEALTH WORKS** **16300 ROSCOE BLVD** **VAN NUYS, CA 91406** **(818) 893-4426**
LOS ANGELES MISSION COLLEGE	**HOLY CROSS HOSPITAL** **15031 RINALDI** **MISSION HILLS, CA 91345** **(818) 365-8051**	**WEST LOS ANGELES COLLEGE**	**BROTMAN MEDICAL CEMTER** **3828 DELMAS TERRACE** **CULVER CITY, CA 90231** **(310) 836-7000**

REFERENCES: EH&S RR-03
8 CCR §9780 et seq

IMPORTANT: SEE INSTRUCTIONS AND INFORMATION ON REVERSE

Issued By: _____ **Title** _____

EH&S RR-03-3 REV. 7 08/02

APPENDIX H
Page 2 of 2

REFERENCES: **EH&S RR-03**
8 CCR §9780 et seq

LOS ANGELES COMMUNITY COLLEGE DISTRICT
REFERRAL FOR TREATMENT OF OCCUPATIONAL INJURY OR ILLNESS
Page 2 of 2

SECTION III: INSTRUCTIONS AND INFORMATION FOR EMPLOYEES

Should you become ill or injured on the job, you are entitled to first aid or emergency medical treatment, as necessary. Emergency medical treatment is that medical treatment reasonably required by an injured employee immediately following an occupational injury or illness which, if delayed, could decrease the likelihood of maximum recovery.

You are required to report all occupational injuries or illnesses to your onsite supervisor. In the event that the injury or illness requires medical treatment beyond "first aid" or results in "lost time" beyond the date of injury, the District must provide you with DWC Form 1, *Employee's Claim for Workers' Compensation Benefits*. "First aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation, is considered first aid, even though provided by a physician or registered professional personnel. "Lost time" means absence from work for a full day or shift beyond the date of injury or illness. You should have received DWC Form 1 at the time you reported the injury to your supervisor. If you did not receive this form or if the injury or illness subsequently requires medical treatment beyond first aid or results in lost time, please telephone the District Workers' Compensation Office. A DWC Form 1, *Employee's Claim for Workers' Compensation Benefits,* will be immediately mailed to your home of residence.

If you have not pre-designated your personal physician in writing prior to the date of this occupational injury or illness, then your initial medical treatment will be directed by a physician and facility authorized by the District. These locations and telephone numbers are provided on the front side of this form. Take this form with you in reporting for your initial treatment. Within the first thirty (30) days following the date the occupational injury or illness was first reported, you may request an alternate physician from the Third Party Administrator and the request shall be honored within five (5) days. After thirty (30) days from the date the occupational injury or illness was first reported, you may change your treating physician to one of your own choosing by notifying, in writing or by telephone, the District Workers' Compensation Office or Third Party Administrator.

If you have pre-designated your personal physician prior to the date of this occupational injury or illness, then your initial medical treatment may be directed by your personal physician or you may report for treatment at the appropriate authorized District location. For the purpose of utilizing an employee-selected physician, initial medical treatment does not include first aid or emergency medical treatment. If you are in need of transportation from work in order to receive treatment, you may only be transported to the appropriate authorized District location, as listed on the front side of this form. Your onsite supervisor is responsible to coordinate any needed transportation.

SECTION IV: INSTRUCTIONS AND INFORMATION FOR PHYSICIANS

CAUTION: If you are the employee's personal physician who undertakes to provide treatment pursuant to Labor Code Section 4600 for occupational injuries and illnesses, you must follow all of the filing, reporting, and time requirements specified in Title 8 California Code of Regulations Section 9785, *Duties of the Employee-Selected Physician.*

The Los Angeles Community College District is a self-insured employer with Third Party Administrator (TPA). **Within three (3) working days** after undertaking to provide initial treatment, you must notify the TPA of the name and address of the treating physician or facility, unless already listed as a District authorized health care facility. These facilities are listed on the front side of this form. **Within five (5) working days** of your initial examination for every occupational injury or illness, you must send two (2) copies of the completed State of California Form 5021, *Doctor's First Report of Occupational Injury or Illness*; one copy to the District and one copy to the TPA. Where the employee has been exposed to bloodborne pathogens, regulated carcinogens, or toxic substances, you are required to provide the District and TPA with your written opinion in accordance with any applicable Section of Title 8, California Code of Regulations for the specific substance within fifteen (15) days of your completed evaluation. Send all required reports and correspondence to the District and TPA. For timely payment, you may send invoices directly to the TPA.

DISTRICT		THIRD PARTY ADMINISTRATOR (TPA)
LOS ANGELES COMMUNITY COLLEGE DISTRICT		OCTAGON RISK SERVICES, INC.
770 WILSHIRE BLVD., 3RD FLOOR		16501 VENTURA BLVD., SUITE 447
LOS ANGELES, CA 90017		ENCINO, CA 91436
ATTN: WORKERS' COMPENSATION OFFICE		ATTN: LACCD TPA
TELEPHONE	(213) 891-2397	(818) 817-8578 *(Primary)*
TELEPHONE:	(213) 891-2231	(818) 817-8568 *(Secondary)*
FAX:	(213) 891-2490	(818) 817-8561

CAUTION: Failure to tile any of the required reports may result in assessment of a civil penalty.

EH&S RR-03-3 REV. 7 08/02

APPENDIX I
Page 1 of 2

LOS ANGELES COMMUNITY COLLEGE DISTRICT
STATEMENT OF EMPLOYEE'S PRE-DESIGNATED PHYSICIAN AND EMPLOYEE CONSENT

Page 1 of 2

District Information

Los Angeles Community Colleges
Business Services Division – Risk Management
Workers' Compensation Office
770 Wilshire Boulevard, 3RD Floor
Los Angeles, California 90017
Telephone: (213) 891-2397
(213) 891-2231
FAX: (213) 891-2490

Form Instructions

Section I: *Employee print name, SSN, college assignment or District, department, and daytime telephone number*
Section II: *Physician print name, clinic address and telephone number. Physician's signature is required for processing*
Section III: *Employee signature and date required. Return form to the District's Workers' Compensation Office.*
Section IV: *District / Third Party Administrator verification and approval is required.*

SECTION I: ADMINISTRATIVE *(Employee)*

EMPLOYEE NAME *(Print)*		**EMPLOYEE SSN:**	
COLLEGE/DISTRICT *(Print)*		**DEPT./TELEPHONE**	

SECTION II PHYSICIAN'S STATEMENT *(Physician)*
I / We have directed the medical treatment for the above listed individual in the past and retain the medical records and medical history for this individual. Furthermore, I /We agree to provide all necessary and reasonable medical treatment to this individual in the event of an on-the-job injury or illness sustained by the individual while employed with the Los Angeles Community Colleges. I / We agree to abide by the Administrative Director's rules and regulations as stated in Title 8, California Code of Regulations, Section 9785, *Duties of the Employee-Selected Physician*.

PHYSICIAN NAME *(Print)*		**PHYSICIAN SIGNATURE** *(Sign)*	
CLINIC ADDRESS *(Print)*		**CLINIC TELEPHONE**	

SECTION III EMPLOYEE CONSENT *(Employee)*
I hereby request that I be treated by my personal physician, as listed above, in the event of any occupational injury or illness. I understand that in the event of serious injury or illness or during an emergency, the District may not transport me to the above listed physician. Furthermore, I understand that in the event that I cannot provide transportation to my personal physician, the District will only transport me to a District-contracted medical facility for treatment of occupational injuries and illnesses. Finally, I understand that if my personal physician is not available to treat me at the time medical attention is indicated, I must report for treatment at a District-contracted facility.

EMPLOYEE SIGNATURE *(Sign)*		**DATE SIGNED**	

SECTION IV DISTRICT VERIFICATION/APPROVAL *(Workers' Compensation Office/Third Party Administrator)*

RECEIVED BY: *(Print)*		**DATE RECEIVED**	
VERIFIED BY: *(Print)*		**DATE APPROVED**	

REFERENCES: 8 CCR §9785
EH&S RR-03

LACCD EH&S RR-03-5 Rev. 1 02/02

APPENDIX I
Page 2 of 2

REFERENCES: **EH&S RR-03**
8 CCR §9780 et seq

LOS ANGELES COMMUNITY COLLEGE DISTRICT
STATEMENT OF EMPLOYEE'S PRE-DESIGNATED PHYSICIAN AND EMPLOYEE CONSENT
Page 2 of 2

SECTION III: INSTRUCTIONS AND INFORMATION FOR EMPLOYEES

Should you become ill or injured on the job, you are entitled to first aid or emergency medical treatment, as necessary. Emergency medical treatment is that medical treatment reasonably required by an injured employee immediately following an occupational injury or illness which, if delayed, could decrease the likelihood of maximum recovery.

You are required to report all occupational injuries or illnesses to your onsite supervisor. In the event that the injury or illness requires medical treatment beyond "first aid" or results in "lost time" beyond the date of injury, the District must provide you with DWC Form 1, *Employee's Claim for Workers' Compensation Benefits*. "First aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation, is considered first aid, even though provided by a physician or registered professional personnel. "Lost time" means absence from work for a full day or shift beyond the date of injury or illness. You should have received DWC Form 1 at the time you reported the injury to your supervisor. If you did not receive this form or if the injury or illness subsequently requires medical treatment beyond first aid or results in lost time, please telephone the District Workers' Compensation Office. A DWC Form 1, *Employee's Claim for Workers' Compensation Benefits,* will be immediately mailed to your home of residence.

If you have not pre-designated your personal physician in writing prior to the date of this occupational injury or illness, then your initial medical treatment will be directed by a physician and facility authorized by the District. These locations and telephone numbers are provided on the front side of this form. Take this form with you in reporting for your initial treatment. Within the first thirty (30) days following the date the occupational injury or illness was first reported, you may request an alternate physician from the Third Party Administrator and the request shall be honored within five (5) days. After thirty (30) days from the date the occupational injury or illness was first reported, you may change your treating physician to one of your own choosing by notifying, in writing or by telephone, the District Workers' Compensation Office or Third Party Administrator.

If you have pre-designated your personal physician prior to the date of this occupational injury or illness, then your initial medical treatment may be directed by your personal physician or you may report for treatment at the appropriate authorized District location. For the purpose of utilizing an employee-selected physician, initial medical treatment does not include first aid or emergency medical treatment. If you are in need of transportation from work in order to receive treatment, you may only be transported to the appropriate authorized District location, as listed on the front side of this form. Your onsite supervisor is responsible to coordinate any needed transportation.

SECTION IV: INSTRUCTIONS AND INFORMATION FOR PHYSICIANS

CAUTION: If you are the employee's personal physician who undertakes to provide treatment pursuant to Labor Code Section 4600 for occupational injuries and illnesses, you must follow all of the filing, reporting, and time requirements specified in Title 8 California Code of Regulations Section 9785, *Duties of the Employee-Selected Physician.*

The Los Angeles Community College District is a self-insured employer with Third Party Administrator (TPA). **Within three (3) working days** after undertaking to provide initial treatment, you must notify the TPA of the name and address of the treating physician or facility, unless already listed as a District authorized health care facility. These facilities are listed on the front side of this form. **Within five (5) working days** of your initial examination for every occupational injury or illness, you must send two (2) copies of the completed State of California Form 5021, *Doctor's First Report of Occupational Injury or Illness*; one copy to the District and one copy to the TPA. Where the employee has been exposed to bloodborne pathogens, regulated carcinogens, or toxic substances, you are required to provide the District and TPA with your written opinion in accordance with any applicable Section of Title 8, California Code of Regulations for the specific substance within fifteen (15) days of your completed evaluation. Send all required reports and correspondence to the District and TPA. For timely payment, you may send invoices directly to the TPA.

DISTRICT		THIRD PARTY ADMINISTRATOR (TPA)
LOS ANGELES COMMUNITY COLLEGE DISTRICT		OCTAGON RISK SERVICES, INC.
770 WILSHIRE BLVD., 3RD FLOOR		16501 VENTURA BLVD., STE. 447
LOS ANGELES, CA 90017		ENCINO, CA 91436
ATTN: WORKERS' COMPENSATION OFFICE		ATTN: LACCD TPA
TELEPHONE	(213) 891-2397	(818) 817-8584
TELEPHONE:	(213) 891-2231	(818) 817-8578
FAX:	(213) 891-2490	(818) 817-8561

CAUTION: Failure to tile any of the required reports may result in assessment of a civil penalty.

EH&S RR-03-5 Rev. 1 02/02

APPENDIX J

LOS ANGELES COMMUNITY COLLEGE DISTRICT
COLLEGE SHERIFF DEPARTMENT TELEPHONE LIST

COLLEGE	NOTES		TELEPHONE
LOS ANGELES CITY COLLEGE	1,2		(323) 662-5276*
			(323) 662-5319
			(323) 662-5812
		FAX:	(323) 664-3798
EAST LOS ANGELES COLLEGE	3		(323) 265-8800*
			(323) 265-8672
			(323) 265-8400
		FAX:	(323) 260-8141
LOS ANGELES HARBOR COLLEGE			(310) 233-4600*
		FAX:	(310) 233-4678
LOS ANGELES MISSION COLLEGE	4		(818) 364-7843*
			(818) 364-7844
			(818) 364-7845
			(818) 364-7846
		FAX:	(818) 364-7816
LOS ANGELES PIERCE COLLEGE	5		(818) 719-6450*
			(818) 710-4350
			(818) 710-2810
		FAX:	(818) 992-6712
LOS ANGELES SOUTHWEST COLLEGE	1,2		(323) 241-5311*
			(323) 241-5269
		FAX:	(323) 241-5205
LOS ANGELES TRADE-TECHNICAL COLLEGE	2		(213) 763-3600*
			(213) 763-3604
		FAX:	(213) 763-5372
LOS ANGELES VALLEY COLLEGE	2		(818) 947-2911*
		FAX:	(818) 947-2910
WEST LOS ANGELES COLLEGE	2		(310) 287-4311*
			(310) 287-4314
			(310) 287-4315
		FAX:	(310) 287-4480
EDUCATIONAL SERVICES CENTER		Los Angeles County Sheriff	(213) 891-2389*
		Building Security	(213) 622-3770*
		Floor Warden Coordinator	(213) 891-2448
		Workers' Compensation Office	(213) 891-2397
		Environmental Health & Safety	(213) 891-2422
		Risk Management	(213) 891-2231

NOTES:
1. Call boxes installed about campus
2. From a payphone, press "#30" for speed dial to Sheriff
3. From a payphone, press "*80" for speed dial to Sheriff
4. From campus phones, press "11" for speed dial to Sheriff
5. From campus phones, press "311" for speed dial to Sheriff

* Designated emergency numbers

APPENDIX K

REFERENCES: **8 CCR §342**
LACCD EH&S EP-02

TELEPHONE NOTIFICATION TO THE DIVISION OF OCCUPATIONAL SAFETY AND HEALTH CHECKLIST

Page 1 of 2

☐	*Los Angeles*	**(213) 576 - 7451**	☐	*Pico Rivera*	**(562) 949 - 7827**
☐	*Torrance*	**(310) 516 - 3734**	☐	*Van Nuys*	**(818) 901 - 5403**

EMPLOYER NAME **ADDRESS** **TELEPHONE NUMBERS**	**Los Angeles Community College District** **770 Wilshire Boulevard** **Los Angeles, CA 90017** **(213) 891-2000** **Operator** **(213) 891-2201** **Chancellor's Office** **(213) 891-2081** **Vice Chancellor - Operations** **(213) 891-2400** **Director - Business Services**		
VIOLENCE EVENT TYPE (✓) *If applicable*	☐ **TYPE I** ☐ **TYPE II** ☐ **TYPE III**	**EVENT** *(Injury/Illness)* **DATE / TIME**	_____/_____
EMPLOYEE NAME FIRST REPORTING EVENT *(Include Job Title and Telephone Number)*	*Name* *Title* *Telephone Number*		
EVENT *(or Injury / Illness)* **SITE LOCATION / ADDRESS TELEPHONE NUMBERS**			
SITE CONTACT PERSON NAME / TITLE *(or "IC" if Incident Commander)*	*Name* *Title* *Telephone Number*		
INJURED EMPLOYEE NAME AND ADDRESS *(Use Reverse Side for Additional Names)*			
Describe or List the Nature of Injury(ies)			
Describe the Event and Whether the Scene has been Altered			
Location(s) Where Injured Employee(s) Moved			
LAW ENFORCEMENT AGENCIES AT SCENE			
NOTIFICATION MADE BY *(Employee Name, Date, Time, and Location from which notification made)*	*Name* *Date / Time* *Location*		

LACCD EH&S EP-02-1 Rev. 2 05/01

APPENDIX K

TELEPHONE NOTIFICATION TO THE DIVISION OF OCCUPATIONAL SAFETY AND HEALTH CHECKLIST

Page 2 of 2

☐	*Los Angeles*	**(213) 576 - 7451**	☐	*Pico Rivera*	**(562) 949 - 7827**
☐	*Torrance*	**(310) 516 - 3734**	☐	*Van Nuys*	**(818) 901 - 5403**

Use Additional Sheets if necessary to List More Employees As Needed

Sheet ____ of ____

INJURED EMPLOYEE NAME AND ADDRESS	
Describe or List the Nature of Injury(ies)	
Describe the Event and Whether the Scene has been Altered	
Location(s) Where Injured Employee(s) Moved	
INJURED EMPLOYEE NAME AND ADDRESS	
Describe or List the Nature of Injury(ies)	
Describe the Event and Whether the Scene has been Altered	
Location(s) Where Injured Employee(s) Moved	
INJURED EMPLOYEE NAME AND ADDRESS	
Describe or List the Nature of Injury(ies)	
Describe the Event and Whether the Scene has been Altered	
Location(s) Where Injured Employee(s) Moved	

REFERENCES: **8 CCR §342**
LACCD EH&S EP-01

LACCD EH&S EP-02-1 Rev. 2 05/01

APPENDIX L

REFERENCE: 8 CCR §9910

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS

FORWARD TO:
P.O. BOX 42400
SAN FRANCISCO, CA 94142

NOTICE OF EMPLOYEE DEATH

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE, REGARDLESS OF THE CAUSE OF DEATH, EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8 CHAPTER 4.5, SECTION 9900).

DECEASED EMPLOYEE

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

_____

JOB TITLE AND NATURE OF DUTIES: _____

_____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____
CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

_____

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

_____

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH?

_____ YES _____ NO

(IF YES, TO WHOM? _____)

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS", IF ONE WAS FILED.

PLEASE NOTE:

IF THE DEATH IS WORK-CONNECTED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH:

TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

( ) INSURED ( ) SELF-INSURED ( ) LEGALLY UNINSURED

EMPLOYER: _____

STREET: _____

CITY/STATE: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____

CITY/STATE: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

BY: _____

TITLE: _____

DIA 510 (Rev. 9/84)

APPENDIX M

LOS ANGELES COMMUNITY COLLEGE DISTRICT
WORKERS' COMPENSATION BENEFITS INFORMATION

Workers' Compensation
California's no-fault compensation was passed by the State Legislature over 75 years ago to guarantee prompt, automatic benefits to employees who sustain on-the-job injuries or illnesses. With a few exceptions, almost every employee, public and private, in the State of California is protected by Workers' Compensation. The State of California supervises both the amount of benefits available under Workers' Compensation and the distribution of payments. A Third Party Administrator *(TPA)* administers the program in consultation with the District to insure that all Workers' Compensation benefits are paid to injured employees in accordance with state regulations.

How to Claim Benefits
Report the injury or illness to your onsite supervisor. You will be given a claim form so that you can describe the injury or illness. Complete the form and return it to your onsite supervisor as soon as possible. Enough information must be included to insure that required reports can be completed and arrangements may be made for medical treatment. Prompt reporting is the key. You have one year from the date of the injury to report your claim. Benefits are automatic, but nothing can happen until the District knows about the injury or illness. Report all injuries, no matter how slight. Injuries resulting from a workplace crime may also be covered under workers' compensation. Coverage begins the moment you are on the job and continues anytime you are working. You don't have to work a certain amount of time or earn a certain amount before you are protected. Check with the District Workers' Compensation Office *(WCO)* should you have any coverage questions (213) 891-2397.

What are the Benefits?
California's Workers' Compensation guarantees injured employees the following benefits:

1. Medical Care;
2. Payment to Replace Lost Wages;
3. Permanent Disability;
4. Rehabilitation Services; and
5. Death Benefit to Eligible Dependents.

Medical Benefits
The District will pay for all necessary doctor bills, hospital costs, x-rays, medications, crutches, etc. to cure and relieve the effects of the occupational injury or illness. If you require treatment in addition to first aid, you will be referred to a doctor or health care organization *(HCO)*, not necessarily one that you know, although that doesn't mean it's a "District Doctor". The physician is a designated panel physician in private practice who will send bills and reports directly to the TPA. You should never see a bill, but in the event one is sent to you, it should be forwarded to the District's WCO.

You are entitled to be treated by your own personal physician if you have notified the District of the doctor's name and address in writing before the occupational injury or illness. "Personal physician" means your regular physician and surgeon who has previously directed your medical treatment and who retains your medical records and history. To pre-designate your personal physician, you and your doctor's office must complete the Statement of Employee's Pre-Designated Physician and Employee Consent Form, available from the District's WCO, and return the completed form to the District. If you haven't pre-designated a physician prior to the occupational injury or illness, you may switch to your own doctor within a reasonable geographical area after the District's medical control expires. This can range from 30 days to one year after reporting the injury, depending upon switching doctors with an HCO. All change of physicians must be reported to the District's WCO.

How Much are the Payments for Lost Wages?
The amount generally is two-thirds of your average weekly wage, up to a maximum amount set by the State of California. The amount of the payments and when and how they will be paid are a part of the state law. Workers' Compensation payments are tax-free. There are no deductions for state or federal taxes, social security, union contributions, etc. If you report the injury or illness promptly, your first temporary disability check should be mailed within 14 days. After that, you will receive a check every two weeks until the doctor releases you to return to work. Payments for lost wages are not made for the first three days you are unable to work (including weekends). However, if you are hospitalized as an in-patient or unable to work for more than 14 days, payments will be made even for the first three days. If you are entitled to salary continuation, temporary disability benefits will be included in your regular paycheck. Temporary disability payments made two or more years after the injury are paid at the current maximum rates, if justified by earnings.

APPENDIX M

LOS ANGELES COMMUNITY COLLEGE DISTRICT
WORKERS' COMPENSATION BENEFITS INFORMATION

Vocational Rehabilitation
If the injury keeps you from returning to your regular work, the District will advise you if your regular job can be modified or if another position can be provided to accommodate your permanent disability. If you are not able to return to your regular job because of disability, you may have rights under the Americans with Disabilities Act or the Fair Employment/Housing Act. For more information, call the Equal Employment Opportunity Commission at (800) 669-4000. If you cannot return to work due to the disability, you may qualify for vocational rehabilitation benefits. A trained counselor will develop a plan to create new job opportunities for you. The District pays all costs up to a maximum set by state law.

Permanent Disability
Additional payments will be made for a permanent handicap such as the amputation of a finger or loss of sight, even though you may be able to return to full employment. The number of permanent disability payments is based on a schedule set by state law. The schedule takes into account your age, occupation at the time of injury or illness, and the nature of the permanent handicap. The weekly benefit is subject to minimums and maximums set by the state, depending upon the date of the injury or illness. After you recover to the fullest extent possible, the doctor who treated you will evaluate the permanent effects of the injury or illness. The District and you may agree to rely on the treating doctor's report to establish your permanent disability payment. If you have any questions about the doctor's report, you may contact an Information and Assistance Officer at the Division of Workers' Compensation. If you don't agree on the treating doctor's report, and an attorney doesn't represent you, you must choose an evaluating doctor from a panel of three independent doctors provided by the state. If an attorney represents you and you don't agree with the treating doctor's report, the attorney will arrange for another medical evaluation. The District's TPA submits all necessary reports to the Division of Workers' Compensation. The Division makes a determination of the nature and extent of your permanent disability.

Death Benefits
In the event of a work-related death, benefit payments to survivors are set by state law according to the number of dependents. Payments are made at the same rate as temporary disability benefits.

What if There are Questions or Problems?
Fortunately most claims are handled routinely. But mistakes and misunderstandings do happen. If you think you haven't received all of your benefits, contact the District's WCO.

If you still have questions, contact the nearest office of the Division of Workers' Compensation. Information and Assistance Officers are employed by the state to protect your rights, review your claim, and let you know what steps you may take. The information and assistance you will receive from the Division is free of charge (800) 736-7401.

Some problems may need to be resolved by the Workers' Compensation Appeals Board. The Board is the state agency responsible for handling disputes. The Appeals Board is a court of law. You may represent yourself or you may want to hire a lawyer. If you hire an attorney, the fee will be deducted from any benefits awarded by the Board. Attorney fees are normally 9-12% of your award. If it is necessary to go to the Appeals Board to resolve your claim, be sure to do it within one year from the date of the injury or illness, or within one year from the date of your last medical treatment. Waiting longer could mean losing your right to benefits.

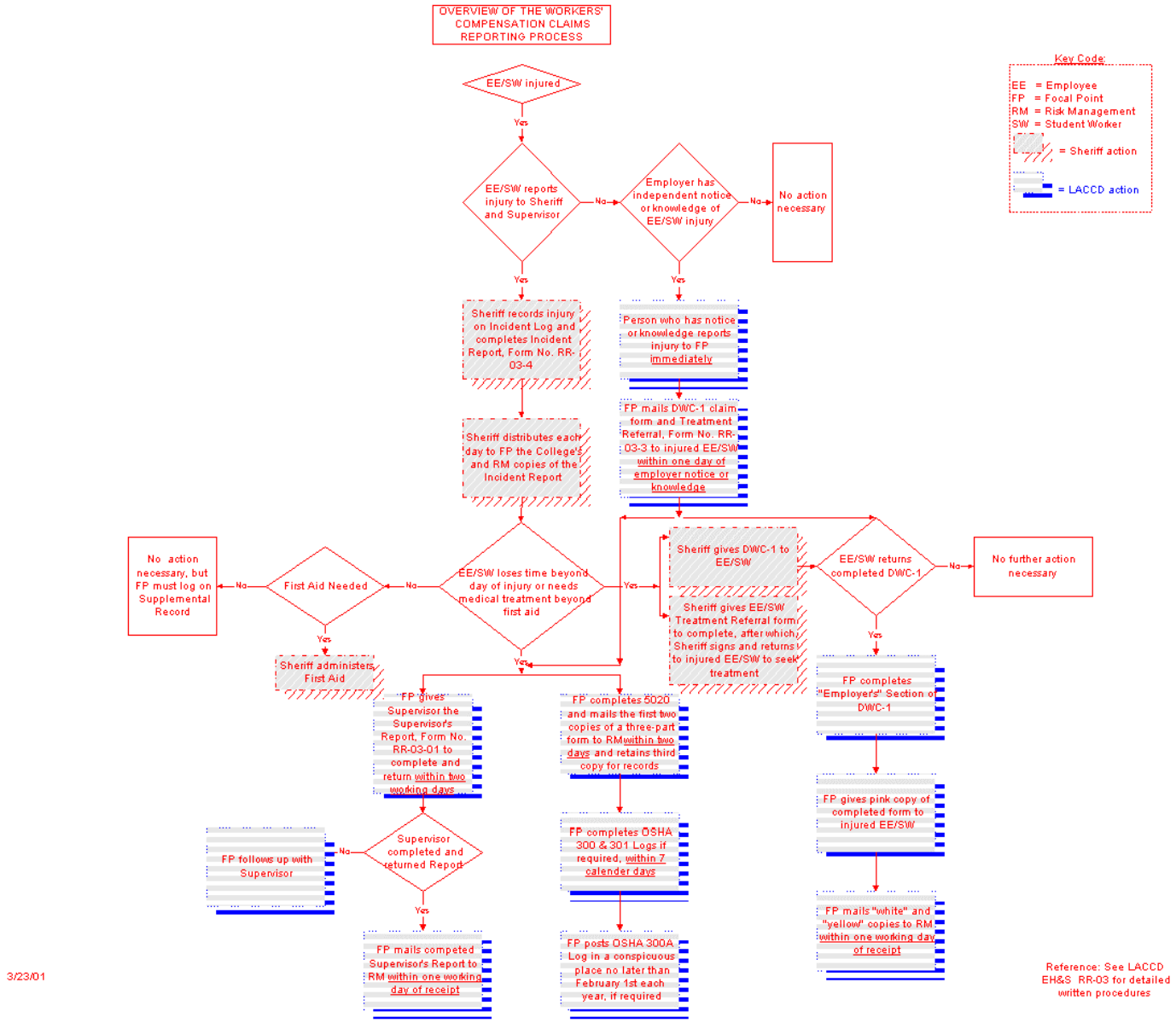
Other Benefits
If the injury is very serious- one where you won't be able to work for a year or more, you may be eligible for additional benefits from Social Security. For information, contact the nearest office of the Social Security Administration. Workers' Compensation sometimes is confused with another state program known as State Disability Insurance (SDI). They seem similar, but there are important differences. Workers' Compensation takes care of on-the-job injuries and illnesses, and is paid for by the District. SDI covers off-the-job injuries or illnesses and is paid for by deductions from your paycheck, if applicable.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who knowingly files or assists in the filing of a false Workers' Compensation claim may be fined up to $50,000 and sent to prison for up to five years (IC §1871.4).

APPENDIX N

LOS ANGELES COMMUNITY COLLEGE DISTRICT REPORTING INJURIES AND ILLNESSES PROCESS MODEL



APPENDIX O

DEVELOPMENTAL RESOURCES

1. Title 8 California Code of Regulations Sections 342, 3203, 9770, 9900 - 9910, and 14000 et seq

2. State of California Labor Code Sections 3200 et seq, 6302, 6313, 6426

3. State of California Penal Code Section 385

4. A Brief Guide to Recordkeeping Requirements for Occupational Injuries and Illnesses, U.S. Department of Labor - Bureau of Labor and Statistics, June 1986

5. Occupational Safety and Health Act of 1970

6. Title 29 Code of Federal Regulations Section 1904