FRESNO STATE
Auxiliary Services

PROCEDURES FOR COMPLETION OF WORK COMP CLAIMS PAPERWORK

Please complete the attached packet in the following manner. Forms must be completed within 24 hours of reporting the injury/illness to supervisor. Notify Human Resources at (559) 278-0865 if paperwork cannot be completed in a timely manner.

Waiving Medical Treatment

If the employee refuses medical treatment, the **Workers' Comp Refusal of Treatment and The Supervisor Accident/Injury Investigation Report** forms must be completed. Return these forms to Human Resources.

Seeking Medical Treatment

The Policy on Absences is given to the employee for work-related injury/illness.

The **"Authorization for Treatment" form is used for referral to San Joaquin Total Care**, our work comp doctors in Fresno. You can also use the form for referral to Clovis Community Hospital Emergency Room, or St. Agnes Hospital Emergency Room. You may complete and indicate the employer is "California State University, Fresno (Foundation, Association, Ag Fdn, or Programs for Children)." Give this form to the employee if referring to doctor.

Form 5020 must be completed by the supervisor. Please be sure to pay special attention to the section describing the injury or illness. Return this form to Human Resources.

Form DWC 1 must be completed by the Employee and Supervisor (employer). Employee must complete the top section, and supervisor completes the bottom section. Please give a copy to the employee. Return the original copy to Human Resources.

The New Claim Injury Form must be signed by the Employee. Return this form to Human Resources.

The Supervisor Accident/Injury Investigation Report must be completed by the supervisor. Please be as specific as possible, indicating "names of witnesses" and "causes of injury/illness". Return this form to Human Resources.

The Worker's Compensation Claim Declaration in Compliance with Labor Code Section 4906(g) must be signed by the Employee. Return this form to Human Resources.

Our work comp carrier is:
State Compensation Insurance Fund
P. O. Box 4000
Fresno, CA 93755
Phone: (559) 433-2700
Fax: (559) 433-2750

Please call Human Resources at 278-0865 if you have questions regarding these forms.

Revised: 07/2012

FRESNO STATE

Auxiliary Services

Contact Sheet

Type of Injury	Who to Contact	Contact Information
All Injuries:	Auxiliary Human Resources Amanda Chamberlain	(559) 278-0865
For an injury that requires immediate medical attention:	911	911
For medical treatment:	San Joaquin Total Care	(559) 251-2225 5361 E. Kings Canyon Fresno, CA 93727
Weekend and After hours medical treatment:	St. Agnes Medical Center	(559) 450-2090 1111 E. Spruce Ave. Fresno, Ca. 93720

Auxiliary Employees consist of the following corporations:

California State University, Fresno Association, Inc.
California State University, Fresno Foundation
California State University, Fresno Agricultural Foundation
Fresno State Programs for Children, Inc.
Associated Students, Inc.

FRESNO STATE
Auxiliary Services

The California State University, Fresno, Associated Students, Inc. policy with regard to absences for work-related injury/illness is as follows:

Employee will be paid for the full shift on the date of injury.

Benefited employees will be charged sick leave for doctor visits, physical therapy appointments, lab work and tests for work-related injury/illness, etc. These absences should be designated with a "C" on attendance reports.

Non-benefited employees should attempt to schedule doctor visits, physical therapy appointments, etc., outside of normally scheduled work hours.

If employee has been released to modified or regular work and is unable to perform work duties, Human Resources should be notified immediately.

Auxiliary Human Resources Office: Telephone 278-0865

San Joaquin TOTALCARE
5361 E. Kings Canyon • Fresno, CA 93727
(559) 251-2225 • FAX (559) 251-9575

AUTHORIZATION FOR TREATMENT

PATIENT NAME: _____

EMPLOYER NAME: _____

DATE OF INJURY (DOI): _____

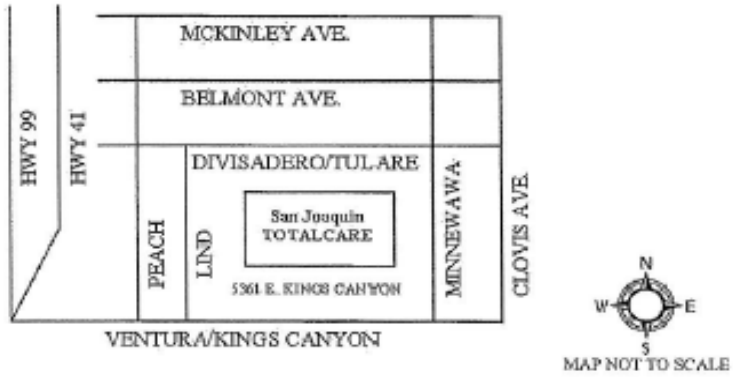
AUTHORIZATION BY: _____ DATE: _____

PHONE: _____

- ☐ W/C INJURY/ILLNESS
- ☐ PRE-PLACEMENT EXAM
- ☐ FITNESS FOR DUTY
- ☐ MEDICAL PHYSICIAN
- ☐ X-RAY
- ☐ DETERMINE WORK RELATED
- ☐ DOT/DMV EXAMINATION
- ☐ SPIROMETRY
- ☐ CHIROPRACTIC PHYSICIAN
- ☐ _____

☐ DRUG / ALCOHOL TEST PLEASE, SPECIFY BELOW:

- ☐ PRE-PLACEMENT
- ☐ POST ACCIDENT
- ☐ DRUG SCREENING (NON-NIDA)
- ☐ DRUG SCREEN (NIDA)
- ☐ DOT/DMV (NIDA)
  - ☐ BREATH ALCOHOL
  - ☐ RANDOM
  - ☐ REASONABLESUSPICION
  - ☐ RETURN TO WORK



Drive 8.4 mi, 10 min

○ 2771 E Shaw Ave
Fresno, CA 93710

Get on CA-168
0.4 mi / 44 s

Continue on CA-168. Take CA-180 E to N Clovis Ave.
Take the Clovis Avenue exit from CA-180 E
6.3 mi / 6 min

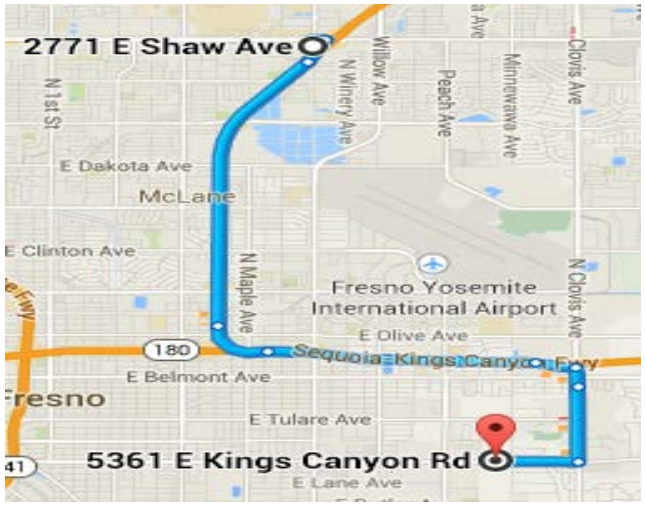
Follow N Clovis Ave to E Kings Canyon Rd
1.7 mi / 3 min

7. Turn right onto N Clovis Ave
0.2 mi

8. Slight right to stay on N Clovis Ave
0.9 mi

9. Turn right onto E Kings Canyon Rd
Destination will be on the right
0.6 mi

◉ 5361 E Kings Canyon Rd
Fresno, CA 93702



State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE COMPENSATION INSURANCE FUND

24-Hour Claims Reporting Center
Telephone: (888) 222-3211 Fax (800) 371-5905

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.

NOTICE: 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 DIVISION
1a. Policy Number
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
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 DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

Please do not use this Column
Case Number
Ownership
Industry
Occupation

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE 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 ☐
15. PAID FULL DAY'S 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)
19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.
19a. BODY PART AFFECTED
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)
20a. ZIP
20b. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
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.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)
27a. Phone Number
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

Days per Week
Weekly Hours
Weekly Wage
County
Nature of Injury
Part of body
Source
Event
Secondary Source
Extent of Injury
Date (mm/dd/yy)

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.*

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
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 ☐ disabled ☐ retired ☐ laid-off ☐ unemployed ☐ on strike ☐ other
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO
40. Number of employees on most recent policy inception or renewal date in effect at time of injury.

Completed By (type or print)
Signature & Title

*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.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or 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, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

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

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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

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

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

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

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

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

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

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

FRESNO STATE
Auxiliary Services

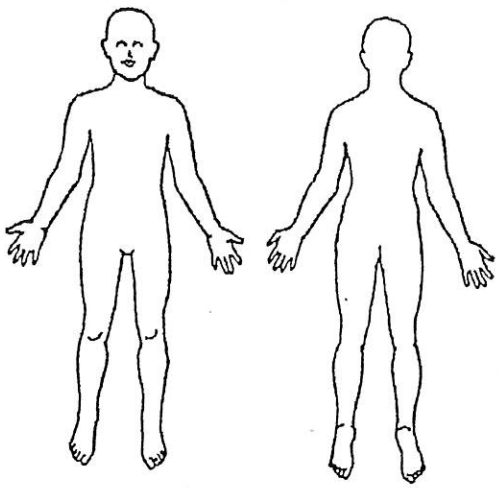
NEW CLAIM INJURY FORM

EMPLOYEE NAME (Nombré):

DATE OF INJURY (Fecha en que se Lastimó):

DESCRIBE HOW THE INJURY OR ILLNESS OCCURRED (Cómo pasó la lesíon o enfermedad):

PLEASE MARK THE BODY PART INJURED (Por favor marque la parte del cuerpo lesionada):



0 1 2 3 4 5 6 7 8 9 10

0= No pain (Ningún dolor) **10= Greatest pain** (Dolor más fuerte)

Please circle the number between 0 and 10 that best describes your pain.
(Por favor circule el número entre el 0 y 10 que mejor describe su dolor).

DISCLAIMER

Any person who makes or causes to be made any false or fraudulent material statement, or material representation for the purpose of obtaining or denying workers' compensation benefits or payment's is guilty of a felony. (Cualquier persona que haga o cause que se produzca cualquier declaración falsa o fraudulenta, o representación material con el propósito de obtener o negar beneficios de compensación al trabajador o el pago, es culpable de un delito grave.)

_____ _____

SIGNATURE OF EMPLOYEE (FIRMA DEL EMPLEADO) **DATE** (FECHA)

FRESNO STATE
Auxiliary Services

SUPERVISOR ACCIDENT/INJURY INVESTIGATION REPORT

Date of Injury: _____

Unit/Division: _____ Location: _____

Injured Employee's Name: _____ Gender: _____ Age: _____

Employment Status: ____Full Time ____Part Time ____Seasonal ____Temporary

Regular assigned position: _____ Length of time in this position _____

Was employee performing a regular job duty? _____ If not, explain:

_____

_____

_____

Was employee working overtime? _____ If yes, explain _____

_____

_____

Does employee work a rotating shift? _____ Was there a recent change in the shift? _____

Explain: _____

Location of accident: _____

Time of Day: _____ Day of Week _____

Body part injured: _____ Right or left side: _____

Type of injury: _____

Severity of injury:

____First Aid _____Dr. Visit _____Emergency Care _____Restricted Duty _____Lost Time

Describe in detail what happened: _____

_____

_____

_____

_____

_____

Has this employee received training in the prevention of this type of injury? _____ Date: _____

Describe any equipment damage/estimate cost:_____

_____

WITNESSES: (Attach written statements)

Name: _____ Job Title: _____ Ph: _____

Name: _____ Job Title: _____ Ph: _____

Name: _____ Job Title: _____ Ph: _____

Name: _____ Job Title: _____ Ph: _____

Employee's Supervisor at time of injury: _____

CAUSES OF ACCIDENT/INJURY: Mark all that apply D=Direct Cause C=Contributing Factor

Environmental:	Work Conditions:	Personal Factors:
___Weather conditions	___Poor housekeeping/clutter	___Unsafe act
___Heat	___Defective equipment/tools	___Lack of knowledge/skill
___Cold	___Inadequate work space	___Improper motivation
___Noise	___Uneven/wet walking surface	___Inadequate planning
___Smoke/fumes	___Inadequate protective equip.	___Fatigue/stress
___Dust	___Inadequate lighting	___Deviation from procedure
___Third party	___Inadequate ventilation	___Violation of safety rule
___Other:_____	___Other:_____	___Other:_____
Job Factors:	Management Issues:	Other Factors:
___Inadequate design	___Insufficient training	___ _____

___Inadequate equip. /tools ___Inadequate planning ___ _____

___Inadequate procedures ___Lack of program support ___ _____

___Inadequate maintenance ___Lack of enforcement ___ _____

___Inadequate inspection ___Budgetary constraints ___ _____

___Inadequate purchasing ___Understaffed ___ _____

CORRECTIVE ACTION PLAN (Include immediate, short term and long term plan):

Immediate Action: _____

Assigned To: _____ Date Completed: _____

Short Term Plan: _____

Assigned To: _____ Date Completed: _____

Long Term Plan: _____

Assigned To: _____ Date Completed: _____

ADDITIONAL INFORMATION:

Investigation completed by: _____ Date: _____

Manager/Director Signature: _____ Date: _____

HR Review Date: _____

FRESNO STATE
Auxiliary Services

(Association, Foundation, Agricultural Foundation, Associated Students, Programs for Children)

Worker's Compensation Claim Declaration in Compliance With Labor Code Section 4906(g)

Policy #_____

It is declared by the undersigned, under penalty of perjury under the laws of the State of California, that I/we have not violated Labor Code Section 139.3 (prohibited physician referrals) and that I/we have not offered, delivered, received, or accepted any unlawful rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

_____ _____
Insurer Signature Date

_____ _____
Attorney Signature Date

FRESNO STATE
Auxiliary Services

WORKERS' COMP
REFUSAL OF TREATMENT

DATE:_____

EMPLOYEE:_____

TYPE OF INJURY: _____

As of the above noted date, I am notifying California State University, Fresno Auxiliary Corporations of an injury that occurred on _____. This injury ☐ was; ☐ was not initially reported by me to my supervisor on _____.

At this time I have been requested by a representative of California State University, Fresno Auxiliary Corporations to be medically evaluated by San Joaquin TOTALCARE. However, I decline to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the Auxiliary health care provider listed below. I also understand that should I decide to seek medical treatment for this injury, I must immediately notify my supervisor and go the below listed provider:

PROVIDER: San Joaquin TOTALCARE
ADDRESS: 5361 E. Kings Canyon
Fresno, CA 93727
PHONE: (559) 251-2225

I, ☐ have; ☐ have not, sought medical treatment for this injury from:

TREATING PHYSICIAN'S NAME/ADDRESS _____
(including City and State)

_____

STATEMENT: I have read and agree that the above information is factual and true.

_____ _____
Employee Signature Date Supervisor Signature Date