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:
AmTrust North America
800 Superior Ave E. 21st Floor
Cleveland, OH 44114
Phone: (866) 272-9267
Fax: (877) 669-9140

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 Fresno State Programs for Children 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

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who 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 is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: www.harborsys.com/ICWGroup

MPN Effective Date 7/1/2017 - 7/1/2018 MPN Identification number: 2299

If you need help locating an MPN physician, call your MPN access assistant at: 800.877.1111 x12759

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: 800.877.1111 x12759

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

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator ICW Group Phone 800.877.1111

Workers' compensation insurer Insurance Company of the West (Enter "self-insured" if appropriate)

You can also get free information from a State Division of Workers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: **www.dwc.ca.gov** and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured Workers."

False claims and false denials. 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty, recreational, social, or athletic activity that is not part of your work-related duties.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados--Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, antes de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico
4. **Red de Proveedores Médicos (MPN):**Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.**Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN:

Página web de la MPN: www.harborsys.com/ICWGroup

Fecha de vigencia de la MPN: 7/1/2017 - 7/1/2018 Número de identificación de la MPN: 2299

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: 800.877.1111 x12759

Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: 800.877.1111 x12759

Discriminación. 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. 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.

¿Preguntas? AAprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos ICW Group Teléfono 800.877.1111

Asegurador del Seguro de Compensación de trabajador Insurance Company of the West (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre la compensación del trabajador en el Internet en**www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquieractividad fuera del trabajo, recreativa, social, o atlética que no sea parte de sus deberes laborales.

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): _____

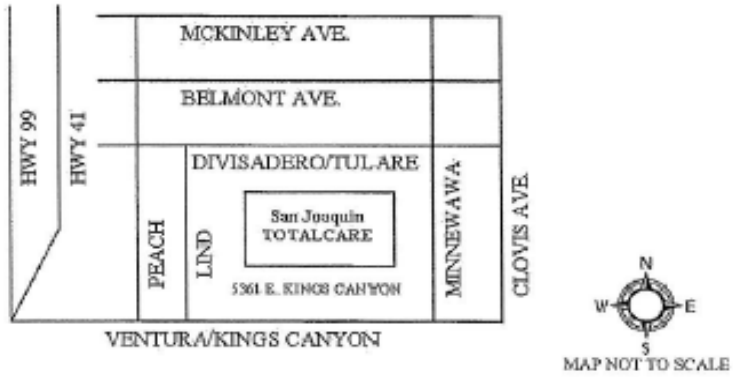
AUTHORIZATION BY: _____ DATE: _____

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

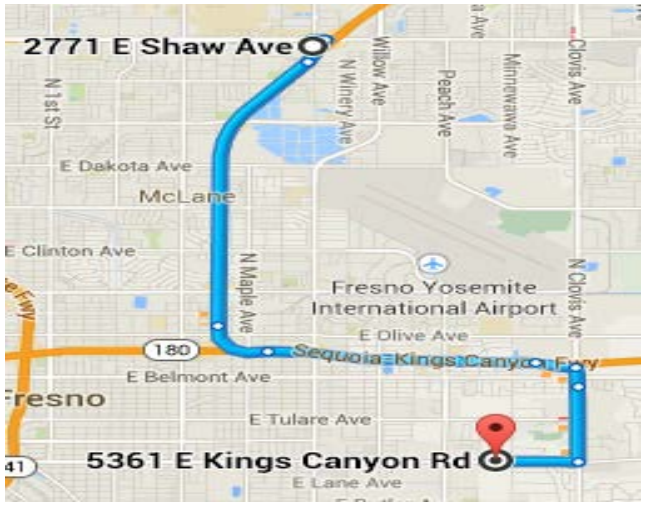
Follow N Clovis Ave to E Kings Canyon Rd
1.7 mi / 3 min

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
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.

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.

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

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde 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.*
    AmTrust North America
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*

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

ICW Group

P.O. Box 85563
San Diego, CA 92186
Toll Free (800) 877-1111 Direct (858) 350-2400

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 telegram to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
Do not use this Column
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
CASE NUMBER
3. LOCATION, If different from Mailing Address (Number and 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.
INDUSTRY
6. TYPE OF EMPLOYER
☐ Private ☐ State ☐ City ☐ County ☐ School District ☐ Other Gov't, Specify: _____
OCCUPATION

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)
SEX
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 ☐
AGE
15. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED" ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYERS KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)
DAILY HOURS
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, Tendonitis of left elbow, lead poisoning
DAYS PER WEEK
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
20A. COUNTY
21. ON EMPLOYERS PREMISES? ☐ YES ☐ NO
WEEKLY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED. E.g. shipping department, machine shop
23. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
WEEKLY WAGE
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED. e.g. Acetylene, welding torch, farm tractor, scaffold:
COUNTY
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED. e.g. welding seams of metal forms, loading boxes onto truck.
NATURE OF INJURY
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.
PART OF BODY
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, ZIP)
27a. Phone Number
SOURCE
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ Yes ☐ No If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, ZIP)
28a. Phone Number
29. Employee Treated in Emergency Room? ☐ Yes ☐ No
EVENT

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)
SECONDARY SOURCE
33. HOME ADDRESS ((number and 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 (check applicable status at time of injury. ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
137b. Under what class code of your policy were wages assigned?
EXTENT OF INJURY
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENT NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, lodging 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.

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**.

FRESNO STATE
Auxiliary Services

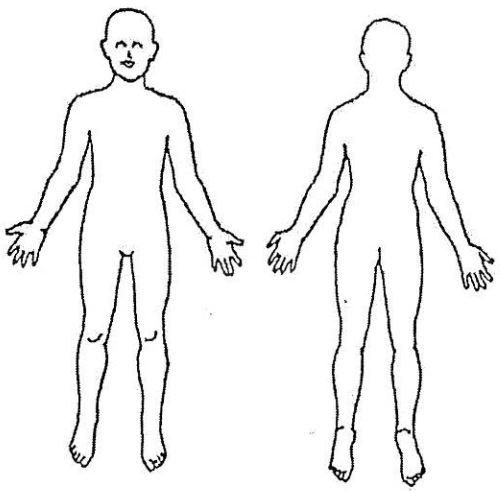
NEW CLAIM INJURY FORM

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