

## OHLONE COMMUNITY COLLEGE DISTRICT

### Workers' Compensation Procedures

#### Who is covered by Worker's Compensation:

*All District employees, Health Sciences students in on-the-job training programs in non-District facilities, and authorized volunteers are covered by the District for Workers' Compensation through the Keenan and Associates.*

#### **Responsibility of Employee**

Employee should *immediately* report an on-the-job injury to his/her supervisor and the Workers' Compensation Coordinator in HR, and complete the "Workers' Compensation Claim Form" (DWC1). The Workers' Compensation Coordinator completes the bottom box of this form.

- If medical treatment is required, employee (or supervisor) must contact the Workers' Compensation Coordinator in HR for referral to the District's Medical Care Providers. (Health Sciences students may be provided emergency first aid/health care on site by hospital/clinic personnel as per the contract with that facility.
- If employee desires to be treated by his/her personal physician, he/she must have a "Personal Physician Request" form on file with the Workers Compensation Coordinator in Human Resources **prior to the injury/illness**.
- If employee does not return to work due to an on-the-job injury, he/she must submit a doctor's note to his/her supervisor and the Workers' Compensation Coordinator stating description of injury and estimated time away from work. Employees who take time off without verified physician authorization will not be eligible for Worker's Compensation benefits. The District is responsible to cover the employee's time away from work for the first appointment. Subsequent appointments will be covered by the employee's available leaves.
- If employee returns to work with limitations (modified), physician progress reports must be submitted to his/her supervisor and the Worker's Compensation Coordinator.
- If employee returns to work without any limitations, employee must submit the medical release to his/her supervisor and the Workers' Compensation Coordinator.

#### **Responsibility of Supervisor:**

- Promptly report all work-incurred injuries to the Workers' Compensation Coordinator, Human Resources.
- Within 24-48 hours of the injury, submit a completed "Supervisor's Report of Injury" form. It should be immediately forwarded to the Workers' Compensation Coordinator.

- If medical treatment is required, supervisor (or employee) must contact the Workers' Compensation Coordinator in HR (Ext. 6445) for referral to the District's Medical Care Providers. (If a "Personal Physician Request" form is on file, the Workers' Compensation Coordinator will authorize the employee to go to his/her own physician.)
- IN AN EXTREME EMERGENCY, dial 9 and then 911. Immediately thereafter, call Campus Police at Ext. 6111 to inform them of the situation.
- If an employee is injured and medical treatment is required between 5 p.m. and 8 a.m., the supervisor should refer the employee to the Kaiser Fremont Clinic (39400 Paseo Padre Parkway) until 9 p.m., or the Washington Fremont Clinic (2500 Mowry Avenue) until 8 p.m., and after those times to either Kaiser Hospital or Washington Hospital. If the employee has a Personal Physician Request Form on file, the employee may go to his/her physician at any time.
- Monitor and report to the Workers' Compensation Coordinator any time away from work charged to Workers' Compensation by an employee.
- Prepare a modified work plan for the employee as directed by the employee's doctor. Submit to the Workers' Compensation Coordinator in Human Resources.

**Responsibility of Employer** (Workers' Compensation Coordinator, Human Resources) :

- Serves as central point for Workers' Compensation claims information.
- Once an injury has been reported, will contact the District Medical Care providers, as necessary, to arrange for medical care for injured employee.
- Within 48-72 hours completes the "Employer's Report of Occupational Injury or Illness" form, coordinates and submits all injury documentation to Keenan and Associates.
- Informs and continues to inform the Supervisor, Payroll, and Keenan of employee's estimated time away from work.
- Upon employee's return to work, will notify the Supervisor, Payroll, Personnel, and ACSIG.

Workers' Compensation forms may be obtained from the offices of Buildings and Grounds, Campus Security, and Human Resources.

## Treatment Authorization

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Patient Name \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Company Name **OHLONE COMMUNITY COLLEGE DISTRICT** Company Phone No. **510 659 6088**

Occupation \_\_\_\_\_

### Work-Related Injury/Illness

*Instructions to employer: Complete the below section if you are requesting an employee be treated for a work-related injury or illness.*

Date of Injury \_\_\_\_\_ Treat as First Aid  Yes  No

Nature of Injury/Illness \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_ Policy No. \_\_\_\_\_ Effective Date: \_\_\_\_\_

### Examinations, Screenings and/or Tests

*Instructions to employer: Complete this section if you are requesting any of the below services.*

**REASON FOR TESTING**

- Pre-Employment
- Random
- Post-Accident/Injury
- Follow-Up
- Return to Work
- Suspicion/Cause

**TYPE OF EXAM**

- Pre-Employment Physical
- Annual Physical
- Fitness for Duty/Return to Work
- DMV/DOT Physical
  - New Cert.
  - Re-Cert.
- Respiratory Mask Fit Test
- Pulmonary function test
- Includes OSHA Questionnaire and Clearance Form
- Other INJURY

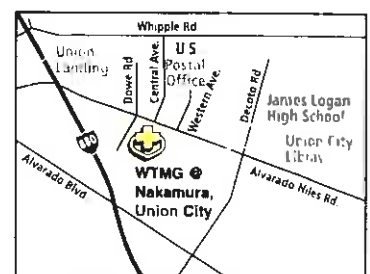
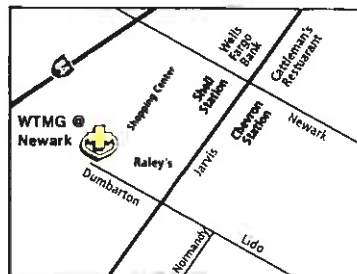
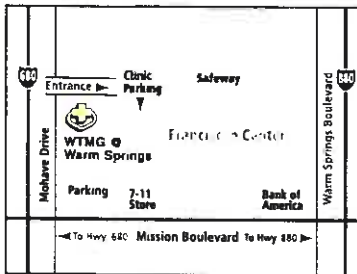
**SUBSTANCE ABUSE**

- Alcohol**
- Breath Alcohol Test
  - Saliva Alcohol
- Drug Screen**
- NIDA (DOT)
  - Non-NIDA (Non-DOT) 5 Panel
  - Non-NIDA (Non-DOT) 10 Panel
  - Rapid (Non-DOT) 5 Panel

Authorized By (Printed Name) \_\_\_\_\_ Phone No. **510 659 6088**

Signature \_\_\_\_\_ Date \_\_\_\_\_

### MUST PRESENT PHOTO IDENTIFICATION AT TIME OF APPOINTMENT



- Refer to
- WTMG @ Warm Springs**  
 46690 Mohave Drive  
 Fremont, CA 94539  
 (510) 651-2371  
 M-F 8am-6pm
  - WTMG @ Newark**  
 35500 Dumbarton Court  
 Newark, CA 94560  
 (510) 797-7535  
 M,T,TH,F 8am-8pm, W 8am-6pm
  - Washington Urgent Care**  
 2500 Mowry Ave, Suite 212  
 Fremont, CA 94538  
 (510) 608-6174  
 Every Day 8am-8pm
  - WTMG @ Nakamura, Union City**  
 33077 Alvarado-Niles Road  
 Union City, CA 94587  
 (510) 487-6000  
 M-F 8am-6pm



**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 diferentes 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 lesiones por un periodo 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

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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](http://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](http://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 atiende, 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 requisitos, 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 Código 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 página Web de la DWC en [www.dwc.ca.gov](http://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 página Web en [www.californiaspecialist.org](http://www.californiaspecialist.org).



**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

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

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

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

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

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

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

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

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

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

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

9. Name of employer. *Nombre del empleador.* OHLONE COMMUNITY COLLEGE DISTRICT
10. Address. *Dirección.* 43600 MISSION BLVD FREMONT, CA. 94539
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.* KEENAN & ASSOCIATES, 1740 TECHNOLOGY DRIVE, SUITE 300, SAN JOSE, CA. 95110
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.* 510-659-6088

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

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

**SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY**

**EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD**

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



# OHLONE COMMUNITY COLLEGE DISTRICT SUPERVISOR'S REPORT OF EMPLOYEE INJURY

(Please complete in detail.)

NAME OF INJURED		S.S. #	AGE	BIRTHDATE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
ADDRESS OF INJURED (street)		(city)		(zip)		
JOB TITLE				SALARY		
NATURE OF INJURY				WAS INJURED ACTING IN REGULAR LINE OF DUTY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
DATE OF INJURY		HOUR	a.m. p.m.	NAMES OF WITNESSES		
DID INJURED REPORT TO A PHYSICIAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME AND ADDRESS OF PHYSICIAN:					
DID INJURED REPORT GO HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE INJURED LEFT THE JOB:			TIME	a.m. p.m.	
DID INJURY REQUIRE HOSPITALIZATION? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE OR ESTIMATED DATE OF RETURN TO WORK:					

**DESCRIBE HOW AND WHERE THE INJURY OCCURRED:**

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### IMMEDIATE SUPERVISOR'S EVALUATION

**Analysis of Injury** Please mark the reasons that, in your opinion, caused the injury. In most cases there will be several reasons under both unsafe conditions and unsafe acts contributing to the injury. *Fill out in detail.*

**AN UNSAFE CONDITION EXISTED:** (check all that apply)

<input type="checkbox"/> Defective equipment, tools	<input type="checkbox"/> Slippery or uneven walking surfaces
<input type="checkbox"/> Equipment not properly guarded	<input type="checkbox"/> Faulty layout of facilities
<input type="checkbox"/> Poor working conditions (light, ventilation)	<input type="checkbox"/> Poor housekeeping
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Non Applicable

What have you done to eliminate this condition?

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**AN UNSAFE ACT RESULTED FROM:** (check all that apply)

<input type="checkbox"/> Lack of training	<input type="checkbox"/> Not using personal safety devices	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Not following rules	<input type="checkbox"/> Physical or mental handicap	<input type="checkbox"/> Improper work method
<input type="checkbox"/> Haste: chance taking	<input type="checkbox"/> Boredom; inattention	<input type="checkbox"/> Improper body position
<input type="checkbox"/> Non Applicable	<input type="checkbox"/> Other (specify) _____	

What have you done to correct this act?

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Supervisor's Signature	DATE
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State of California <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.	
				FATALITY <input type="checkbox"/>	
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.			

EMPLOYEE INFORMATION	1. FIRM NAME OHLONE COMMUNITY COLLEGE DISTRICT		1a. Policy Number		Please do not use this column	
	2. MAILING ADDRESS: (Number, Street, City, Zip) 43600 MISSION BLVD FREMONT, CA. 94539		2a. Phone Number (510) 659-6088			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. EDUCATION		5. State unemployment insurance acct. no.			
	6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input checked="" type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY	
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. DATE LAST WORKED (mm/dd/yy)		13. DATE RETURNED TO WORK (mm/dd/yy)	
	15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> 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 PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning		SEX	
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		23. Other Workers Injured or Ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS		
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold		26. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.		DAYS PER WEEK		
25. 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				WEEKLY HOURS		
27. Name and address of physician (number, street, city, zip)		27a. Phone Number		WEEKLY WAGE		
28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes then, name and address of hospital (number, street, city, zip)		28a. Phone Number		COUNTY		
		29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		NATURE OF INJURY		
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)(8)-(10) & 14300.35(b)(2)(E)Z. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)Z.						

30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/dd/yy)	
33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER		EVENT	
34. SEX <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		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.) <input type="checkbox"/> Yes <input type="checkbox"/> No		EXTENT OF INJURY	

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)
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\* 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.