WORKERS' COMPENSATION SUPERVISORS PACKET

YMCA OF METROPOLITAN LOS ANGELES

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WORKERS' COMPENSATION
YMCA OF METROPOLITAN LOS ANGELES

INITIAL MANAGEMENT AND REPORTING PROCEDRES

The following steps have been established to assist supervisors in caring for employees who are injured while performing their assigned duties.

Once the supervisor is notified of the injury, the supervisor must determine whether the injured worker requires medical attention, and if so, what type:

A. Emergency medical attention

1. Contact 911 immediately! The supervisor will provide the completed ***Medical Authorization Form (A Form)*** to the medical response team upon their arrival. The supervisor must complete an ***Incident Investigation Report*** with details surrounding the incident and include the hospital where the employee is transported to (where applicable). The supervisor should notify the employee's emergency contact of the situation.
2. The supervisor (or designated individual) must immediately notify:
    a) Branch Executive Director (the appropriate Line Officer should be notified in the absence of the Branch Executive Director), and
    b) Workers' Compensation Administrator, Anel Henry (Metro ext. 2216)
3. The supervisor or Human Resources Coordinator must contact Athens to report the injury at (844) 713-7766 and complete the ***Employer's Report of Occupational Injury or Illness (Form 5020).***

B. Non-emergency medical attention

1. The supervisor will complete and provide the ***Medical Authorization Form (A Form)*** to approve the need for treatment.
2. The supervisor and injured employee must complete the ***Workers Compensation Claim Form (DWC 1)***, ***Incident Investigation Report*** and ***Employer's Report of Occupational Injury or Illness (Form 5020).***
3. The supervisor or Human Resources Coordinator must contact Athen to report the injury at (844) 713-7766.
4. The supervisor will provide the employee with the following forms to present to the doctor's office for completion and/or review:
    a) Completed ***Medical Authorization Form (A Form)***
    b) Copy of employee's most current ***Job Description*** to determine return to work status
    c) ***Initial Work Status Report (B Form)*** -the treating physician must complete this form and provide it to the employee to return to the branch
    d) ***Temporary Return to Work Program Form -*** the treating physician must complete this form and provide it to the employee to return to the branch if there are work restrictions
5. The injured employee is referred to:

a) An industrial medical clinic within the MPN which has been pre-selected for the branch or

b) A pre-designated personal physician (the employee must have pre-designated a physician in writing and on file prior to the work related injury).

C. No medical attention

The supervisor must complete an ***Incident Investigation Report*** with details surrounding the incident. The employee must complete the ***Declination of Medical Care Form (C Form)*** for filing and will be monitored to ensure they are feeling well.

RETURN TO WORK

The supervisor must receive written documentation regarding the employee's medical status prior to the employee's return to work:

A. Return to Work with Restrictions

1. The employee must present the ***Initial Work Status Report (B Form)*** or medical release from the treating physician to the supervisor and the ***Temporary Return to Work Program Form***. The supervisor cannot return the employee to their job without these documents. The medical release includes the date of release to return to work and clearly states the limitations or restrictions set forth.
2. The supervisor and the injured worker will review the information received from the doctor and jointly work with the Executive Director and the Workers' Compensation Administrator to determine if appropriate work is available:

    a) The injured worker is returned to work and is closely monitored to ensure compliance with restrictions as set forth by the treating physician until returned to full duty with no restrictions, or

    b) The YMCA cannot provide reasonable accommodations for the work restrictions and the employee is not returned to their assigned job. The supervisor or Human Resources Coordinator must contact the Workers' Compensation Administrator and to inform them modified duty is not available. The employee will be classified as Temporarily Totally Disabled and will be placed on a Leave of Absence until he/she is able to return to work.

Note* Injured employees will be held responsible for following all medical instructions and restrictions, both on and off the job, and attending follow-up appointments.

B. Return to Work with No Restrictions

1. The employee must present the ***Initial Work Status Report (B Form)*** or medical release from the treating physician to the supervisor. The supervisor cannot return the employee to their job without this document. The medical release must state the date of release to return to work and clearly state that there are no limitations or restrictions.

*****Once the claim has been reported to Athens via telephone, all completed forms should be faxed to (949) 878-4840**

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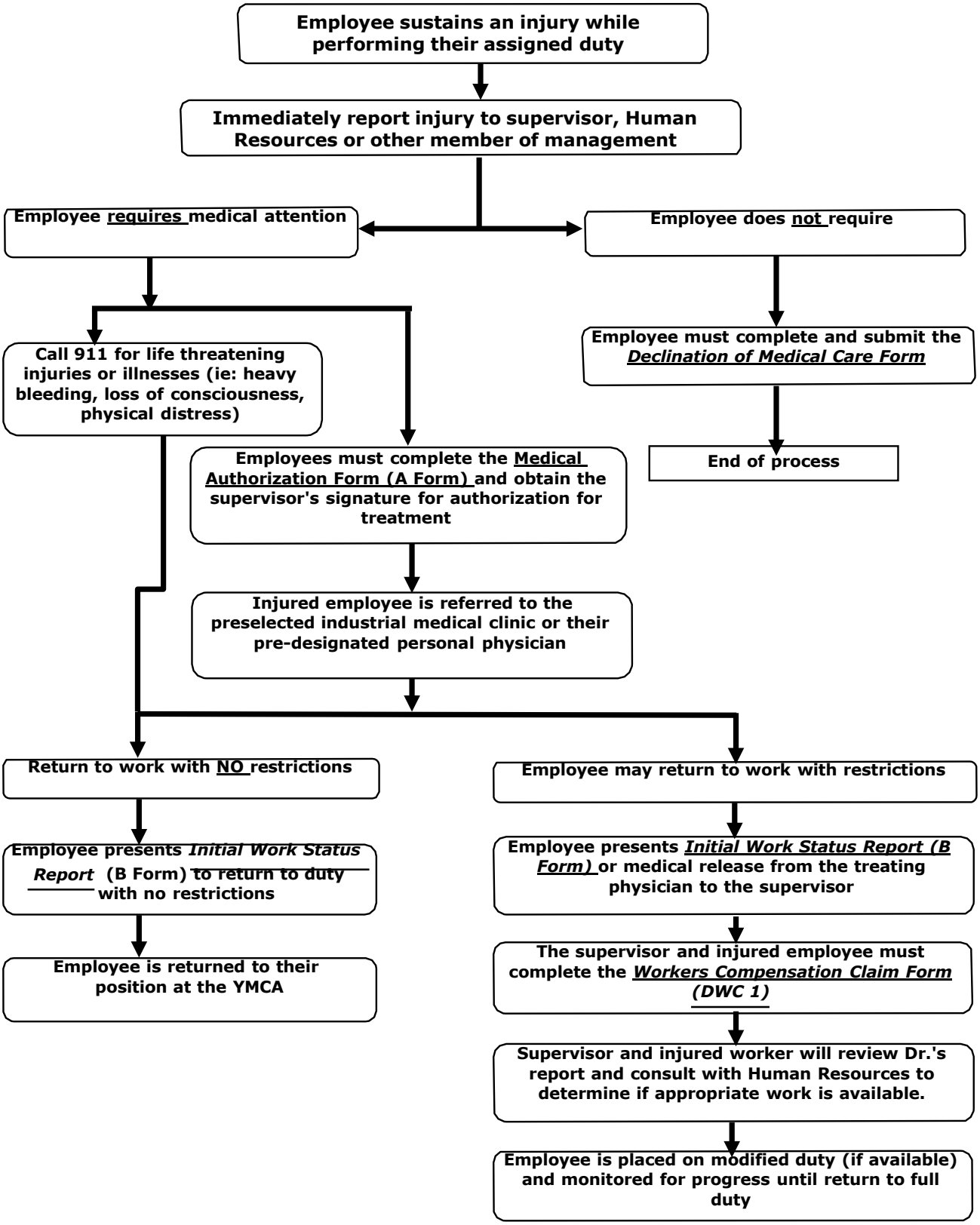
EMPLOYEE INJURY FLOWCHART



Revised June 2011

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

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

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, 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 District ☐ Other Gov't, Specify: _____

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)
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 DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18 DATE EMPLOYEE WAS PROVIDED CLAIM FORM 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
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ 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

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)
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
37. EMPLOYEE USUALLY WORKS _____hours per day, _____days per week, _____total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
38. GROSS WAGES/SALARY $_____per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

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.

A Form

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MEDICAL AUTHORIZATION

Instructions for Injured Employee

Complete the information below and provide this authorization, your current position description and valid identification to the clinic/physician assigned to treat your work-related injury. The treating clinic will keep this form for their records and will provide a work status report to be submitted to the YMCA.

Employee Name: _____
First MI Last

Date of Injury: _____

Body Part(s) Affected: _____

Incident Leading to Injury: _____

_____

_____

_____

Authorization from Employer Representative

Employer Representative Name: _____
(please print)

Position Title & Contact Information: ___

Employer Representative Signature: _____

Authorization Date: _____

Treatment Authorized: ☐ First Aid Treatment ☐ Initial Treatment/Return to Work Evaluation

Instructions for Treating Physician

1. Please use this form as authorization for initial medical treatment of the injured employee named.
2. Please contact the third party administrator (Athens) for authorization after the initial treatment.
3. Please refer to the attached position description to evaluate the injured employee's return to work status. The YMCA will make every effort to accommodate alternate duties on a temporary basis.
4. Attached, please find the Initial Work Status Report Form to be completed and returned to the YMCA.

Billing and Pre-Authorization Information

Third Party Administrator: Athens
PO Box 696
Concord, CA 94522

Phone: (866) 482-3535

Form B

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INITIAL WORK STATUS REPORT

To Be Completed By Physician
The YMCA will make every reasonable effort to provide suitable return to work opportunities for every employee who is unable to perform his/her regular duties following a work related injury.

Date of Evaluation: _____

Date of Injury _____

Patient Name: _____
First MI Last

Diagnosis

_____

_____

BODY PART(S) AFFECTED: _____

_____

☐ WORK RELATED ☐ NON-INDUSTRIAL

Work Status

☐ **FULL DUTY** (no restrictions) beginning as of: _____
Date

☐ **TEMPORARY ASSIGNMENT** (Modified or Alternate Duty) as of: _____
Date

☐ Full-Time ☐ Part-Time (_____hours per day)

Estimated Length of Temporary Assignment: _____

Please list restrictions: _____

_____

_____

_____

☐ **OFF WORK** until re-evaluated, as of: _____
Date

Appointment Date: _____

_____
Physician's Signature Date

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Temporary Return to Work Program

The YMCA of Metropolitan Los Angeles offers temporary, light-duty work for employees who have been injured on the job. Whenever possible, light duty work will be provided.

It is our goal to provide meaningful work activity while avoiding further suffering or aggravation of the injury. Under no circumstances will the injured worker be required to perform duties which are inconsistent with their defined physical limitations.

Please answer the following questions regarding the ability for our employee to return to work.

Patient/Employee Name: _____

Can the injured employee return to their regular work duties? Yes_____No _____

If NO, is the injured employee able to return to modified duty work? Yes_____No _____

Date modified duty begins:_____Date modified duty ends: _____

Please note the injured employees work restrictions:_____

_____

_____

_____

_____

If the employee is unable to return to work at this time, please note when the employee can return to modified duty work or resume full duties in the future:

_____

_____

_____

_____

Doctor Signature_____Date _____

Doctor Printed Name_____Phone _____

Please return this form to:

Address: YMCA Metropolitan Los Angeles
Attn: Anel Henry, Risk Manager
625 S. New Hampshire Avenue
Los Angeles, CA 90005
Fax: (213) 351-2231