INJURY AND ILLNESS PREVENTION PROGRAM

Division of Administrative
Services, Risk Management
200 Kalmus Drive
Costa Mesa, CA 92626
Revised: March 22, 2022

SECTION I

STATEMENT OF SAFETY POLICY

The Orange County Department of Education (OCDE) believes our staff, students, and visitors benefit from a safe and healthy environment. We are committed to maintaining an injury and illness free workplace as well as complying with applicable State and Federal laws and regulations.

Unfortunately, accidents sometimes take place in the workplace and safety is everyone's responsibility. In order to reduce accidents and enhance workplace safety, OCDE has instituted a comprehensive Injury and Illness Prevention Program (IIPP). As a result, this handbook is intended to provide information to all employees about the IIPP and its safety and health policies and procedures.

Each of us can take positive action that will minimize risk and prevent accidents. These actions should include maintaining a conscious awareness of safety, carefully following OCDE's guidelines, and promptly reporting unsafe conditions.

SECTION II

INTRODUCTION

The Orange County Department of Education's (OCDE) primary functions are to educate children and support educators and families throughout Orange County. Educating our employees about safety is also very important to OCDE. As a result, the Injury and Illness Prevention Program (IIPP) is OCDE's overall safety program; and this document, which is intended to ensure compliance with California Code of Regulations, Title 8, Chapter 4, Subchapter 7, and Section 3203, defines specific workplace safety responsibilities and procedures.

This handbook describes the goals, statutory authority, and the responsibilities for all employees under the IIPP. To be successful, the program not only requires cooperation in all safety and health matters between supervisor and employee, but also between each employee and his/her co-worker.

OCDE employees may report to Risk Management any safety- or health-related issue or concern they may have anonymously and without fear of reprisal. It is the obligation of every employee to comply with the requirements of the IIPP at all times.

The IIPP will include the following parts: Policy Statement, Responsibilities, Compliance, Communication, Hazard Assessment, Hazard Control, Accident/Injury Reporting Procedures, Accident/Injury Investigation, Training/Instruction, and Record Keeping. Appendices are also included to provide further reference.

SECTION III

RESPONSIBLITY

All managers, supervisors, and lead personnel are responsible for implementing the IIPP and for ensuring the health and safety of OCDE's employees, students, and faculties.

Managers/Supervisors must effectively execute the following responsibilities to achieve OCDE's safety goals:

1. Familiarize yourself with OCDE's IIPP, and ensure its effective implementation.
2. Conduct inspections on a scheduled basis. Enforce good housekeeping, and take prompt corrective action to eliminate workplace hazards.
3. Provide safety training. Teach general safety regulations and job specific safety rules to employees prior to assignment of duties. Follow up periodically to ensure employees follow safe work procedures.
4. Investigate or review all accidents resulting in employee injury and property damage.
5. Review Material Safety Data Sheets (MSDS) with employees working near and/or with hazardous materials.
6. Support the Risk Management Coordinator and all programs and committees that promote safety and health.

To be successful, the program requires cooperation in all safety and health matters between manager/supervisor and employee and between each employee and his/her co-worker. Consequently, all employees are responsible for using safe work practices; for following all directives, policies, and procedures; and for assisting in maintaining a safe work environment.

Employees must also effectively execute the following responsibilities to achieve OCDE's safety goals:

1. Follow all safety rules and regulations.
2. Wear appropriate safety equipment as required by the job.
3. Report ALL injuries and unsafe conditions and practices to our manager or supervisor.
4. Ask questions if there is a misunderstanding on how to perform a task. Do not attempt to perform any job or operate any machinery on which you have not been properly trained.
5. Contribute ideas or suggestions to improve the safety program.

SECTION IV

COMPLIANCE

Management is responsible for ensuring that all safety and health policies and procedures are clearly communicated and understood by all employees. Managers and supervisors are expected to enforce the IIPP rules fairly and uniformly. OCDE maintains an open door policy allowing all employees to communicate any safety concerns.

All employees are responsible for using safe work practices; for following all directives, policies, and procedures; and for assisting in maintaining a safe work environment.

Our system of ensuring that all employees comply with the rules and maintain a safe work environment includes:

1. Informing employees of the provisions of our IIPP.
2. Evaluating the safety performance of all workers.
3. Recognizing employees who perform safe and healthful work practices.
4. Providing training to employees whose safety performance is deficient.
5. Disciplining employees for failure to comply with safe and healthful work practices.
6. OCDE is also committed to providing all necessary personal protective equipment and safety training to employees at no cost to the employee.

SECTION V
COMMUNICATIONS

The Orange County Department of Education (OCDE) recognizes that open, two-way communication between management and staff on health and safety issues is essential to an injury-free, productive workplace. The following system of communication is designed to facilitate a continuous flow of safety and health information between management and staff in a way that is readily understandable and encourages employees to inform management of workplace hazards without fear of reprisal. The system consists of one or more of the following items:

1. All new employees of OCDE are required to attend a new-hire orientation, which includes a discussion of safety and health policies and procedures.
2. A system to solicit employees' ideas for improving safety can be achieved by completing the Employee Safety and Health Concern Form set out in ***Appendix 1*** and providing this document to your supervisor or OCDE's Risk Management Coordinator. This form can be used for employees to anonymously inform management about workplace hazards without fear of reprisal.
3. Safety meetings are held to discuss safety items and encourage open discussion between employees and management.
4. Safety trainings will be provided through dialog between trainer and trainee, safety videos, safety literature, hands-on examples, on-the-job training, seminars, and workshops.
5. Any safety or health code violations will be posted at the work site where such violations occurred in accordance with the laws of the governing jurisdiction of the agency providing the citation.
6. Warning signs and other indicators of a hazardous condition will also be posted at the work site where hazards exist in accordance with applicable laws.

SECTION VI

HAZARD ASSESSMENT & CORRECTION

HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards shall be performed by the Site Administrator and documented by using the *Good Repair/Safety Report* (***Appendix 2***). Circumstances that may trigger additional inspections may include, but are not limited to, the following:

1. When our Injury and Illness Prevention Program was initially established.
2. Whenever new equipment that presents a new hazard is introduced to the workplace.
3. When periodic unscheduled safety inspections of all areas are conducted by the Risk Management Coordinator to assist in the maintenance of a safe and healthful workplace.
4. When new, previously unidentified hazards are recognized.
5. When occupational accidents occur, to identify and correct hazards that may have contributed to the accident.
6. When permanent or part-time workers are hired or re-assigned to processes, operations, or tasks for which a hazard evaluation has not been previously conducted.

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices, or procedures shall be corrected in a timely manner based on the severity of the hazards. Hazards shall be corrected according to the following procedures:

1. Hazards observed or discovered by any means shall be reported to the Site Administrator.
2. The Site Administrator shall submit a work order request to Maintenance and Operations for correction of the hazardous condition(s), identifying the work order as a "safety priority."
3. Maintenance and Operations shall conduct the requested hazard abatement and notify the Site Administrator when completed.
4. If the best method of correcting the hazardous condition or practice is not apparent or obvious, the Site Administrator should contact the Risk Management Coordinator.
5. When an imminent hazard exists that cannot be immediately abated without endangering employees and/or property, all exposed workers will be removed from the area except those necessary to correct the existing condition. Workers who are required to correct the hazardous condition shall be provided with the necessary protection.

SECTION VII

ACCIDENT REPORTING & INVESTIGATION

ACCIDENT REPORTING

Employees must immediately report all injuries or near misses to their Supervisor. In the event of a "serious incident," the Supervisor will call 911 as appropriate and then notify the Risk Management Department at (714) 966-4059. Following a workplace accident or illness the Supervisor or designee will:

1. Give the Employee the *DWC 1* form (***Appendix 3***) and complete the *Supervisor's Report of Injury Form* ***(Appendix 4***).
2. If no medical treatment is required, the Supervisor will forward the *Supervisor's Report of Injury Form* to the Risk Management Department.
3. Upon receipt of the completed *DWC 1* form from the Employee, the Supervisor or designee will complete the "Employer" section of the form and forward it to the Risk Management Department.
4. If medical treatment is required, the Supervisor or designee will complete and give the Employee the *Workers' Compensation Medical Service Order* form (***Appendix 5***) to receive medical attention at one of OCDE's approved medical facilities (***Appendix 6***).
5. After seeking medical attention, if the Employee is authorized to return to work, he/she must provide a work status report releasing him/her to return to work. The form must be presented to the Risk Management Department and/or the Supervisor. If there are any work restrictions, a determination will be made by the Risk Management Coordinator and the Supervisor whether temporary accommodations can be made or if modified duties are available.
6. The Employee will return to the physician for a follow-up evaluation and a return-to-work status.

NOTE: Supervisors may obtain all required forms from OCDE's intranet website under E-Forms.

ACCIDENT INVESTIGATION

Investigation of workplace accidents, hazardous substance exposure, and near-accidents will be done by the Supervisor and will include:

1. Visiting the incident scene as soon as possible.
2. Interviewing the injured employee and witnesses regarding how the injury/illness occurred.
3. Examining the workplace for factors associated with the accident/exposure/near-accident.
4. Determining through this investigation what corrective actions, if any, are required.
5. Notifying the Risk Management Department at (714) 966-4022 of all reported injuries or illnesses.

6. Conducting a follow-up investigation, if deemed appropriate, by the Risk Management Coordinator and documenting accordingly.

SECTION VIII

TRAINING AND INSTRUCTION

All workers, including managers and supervisors, shall have training and instruction on general and job-specific safety and health practices. Employees attending or receiving training mandated by this program will sign attendance sheets and actively participate in trainings.

Training will be provided when:

1. The program is first established.
2. New employee orientation will include safety and health training. This training shall be documented, and all documentation should be maintained in the employee's personnel file.
3. An employee is potentially exposed to new hazards.
4. An employee is assigned to new work tasks.
5. New chemicals, materials, equipment, or processes are introduced into the workplace.
6. An employee's safety performance is deficient.

What training is provided:

1. Explanation of the OCDE's IIPP, Emergency Preparedness Plan, and measures for reporting unsafe conditions, work practices, injuries, and when additional instruction is needed.
2. Potential hazards in their workplace and those specifically related to their job assignment.
3. The means of minimizing potential hazards, including work conditions, safe work practices, and personal protective equipment.
4. Provisions for medical services and first aid, including emergency procedures.

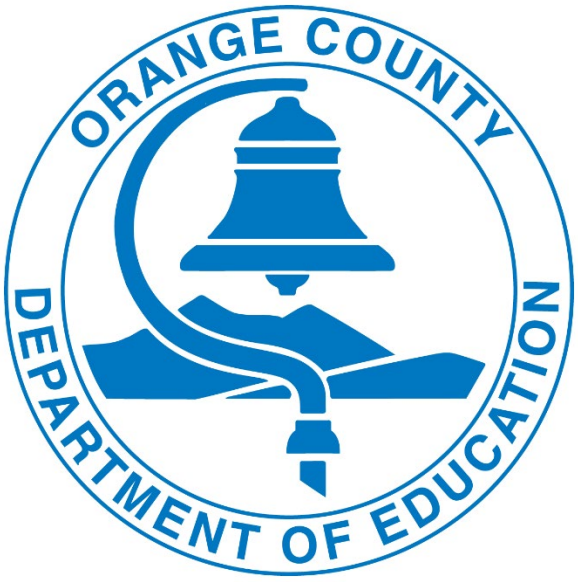
SECTION IX

RECORD KEEPING

The Risk Management Department will ensure retention of the following documents at the Orange County Department of Education for five years:

1. Site safety inspection records.
2. Regulatory citations and Corrective Action Notices.
3. Employee accident investigation reports.
4. Workers' compensation claims.
5. Employee training records.

Injury and Illness Prevention Program



Appendix 1

Employee Safety and Health Concern Form

Employee Safety and Health Concern Form

For imminent hazards or threats or emergencies, please call 911
For non-emergency concerns, please complete and fax this form to 714-549-4812

Orange County Department of Education recognizes that to maintain a safe and secure workplace, there must be open, two-way communication that allows employees to report all potentially unsafe conditions without fear of reprisal. Please complete this form to suggest ideas or report an unsafe workplace condition or practice. You can also call OCDE's Risk Management Coordinator at (714) 966-4059 to report any unsafe conditions.

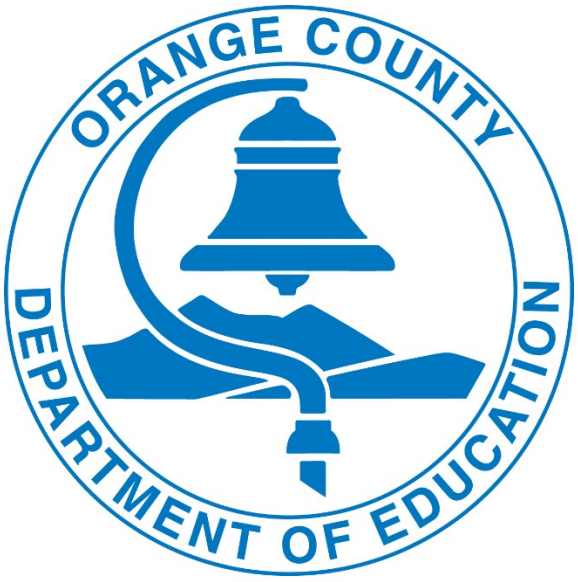
Please describe what OCDE can do to improve safety:

Please describe any unsafe workplace condition or practice:

Has this matter been reported to the area supervisor? ____Yes ____No

Employee Name: (optional): Date:
Work Area:

Injury and Illness Prevention Program



Appendix 2

Good Repair/Safety Report

ORANGE COUNTY DEPARTMENT OF EDUCATION

GOOD REPAIR*/SAFETY REPORT

The original report is to be submitted to Risk Management and one copy to the Program Director **no later than the 10th of each month.**

Division	Site	Reporting Month	Date

Current Uniform Complaint Procedures Posted in All Classrooms ☐ **Yes** ☐ **No** **List Rooms:** _____

I have personally made the following observations, including:

Safety Standards With Children & Staff Observed	☐Yes ☐No ☐N/A	Safety Standards in Health Care Observed	☐Yes ☐No ☐N/A	Food Processing & Servicing Practices	☐Yes ☐No ☐N/A

I have personally observed the various physical properties of this site, including:

Restrooms	☐Yes ☐No ☐N/A	Drinking Fountain	☐Yes ☐ No ☐N/A	Athletic Equipment	☐Yes ☐No ☐N/A	Playground Equipment/ School Grounds	☐Yes ☐No ☐N/A
Railings, Steps, & Stairways	☐Yes ☐No ☐N/A	Structural Damage	☐Yes ☐No ☐N/A	Windows, Doors, Gates Fences	☐Yes ☐No ☐N/A	Interior Surfaces (Walls, Floors & Ceilings)	☐Yes ☐No ☐N/A
Pest/Vermin Infestation	☐Yes ☐No ☐N/A	Hazardous Material (Interior & Exterior)	☐Yes ☐No ☐N/A	Scientific Equipment	☐Yes ☐No ☐N/A	Fire Safety: Extinguishers, Sprinklers Alarms	☐Yes ☐No ☐N/A
Administration Office, Kitchen Facilities Living Quarters including Halls & Classrooms			☐Yes ☐No ☐N/A	Overall Cleanliness	☐Yes ☐No ☐N/A	Roofs	☐Yes ☐No ☐N/A

To the best of my knowledge, the following systems are functioning normally:

Sewer	☐Yes ☐No ☐N/A	Gas Leaks	☐Yes ☐No ☐N/A	Electrical (Interior/Exterior)	☐Yes ☐No ☐N/A	Mechanical Systems: HVAC	☐Yes ☐No ☐N/A

After observing this school and its grounds, did you find any condition(s) that, in your opinion, may be the cause of an injury of illness?
☐ Yes ☐ No If yes, please explain:_____

Were there any incidents of crime and violence on school grounds or in school program and activities? ☐ Yes ☐ No

Did you conduct a SB198 Injury/Illness Prevention Program – Monthly Training? ☐ Yes ☐ No
If yes, please attach a copy of the sign-in sheet.

FIRE DRILL (Required Monthly)	EARTHQUAKE DRILL (Required Quarterly)	DETECTORS CHECKED (Required Quarterly)	FIRE DETECTOR
Date of Drill: _____ Time of Drill:_____ Time of Evacuation: _____	Date of Drill: _____ Time of Drill:_____ Time of Evacuation: _____	Date: _____	Smoke Detector Sprinkler System Other - _____

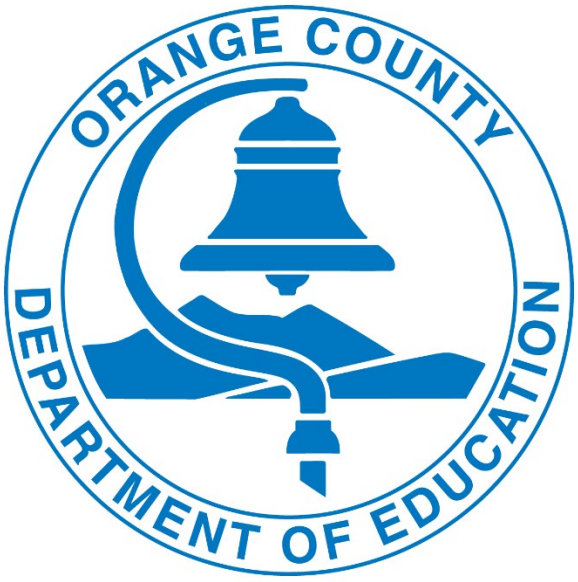
Inspected by: _____ Phone #: _____ Date: _____
(Please print name)

Principal/Supervisor: _____ Phone#: _____ Date: _____

*EC Section 17070.75(e)
Facility Inspection System

Revised 08/15/13

Injury and Illness Prevention Program



Appendix 3

Workers' Compensation Claim Form DWC 1

§ 10139. Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility.

Note: Authority cited: Sections 133 5307.3 and 5401, Labor Code. Reference: Sections 132(a), 139.48, 139.6, 4600, 4600.3, 4601, 4604.5, 4616, 4650, 4656, 4658.5, 4658.6, 4700, 4701, 4702, 4703, 5400, 5401, 5401.7 and 5402, Labor Code.

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. Use the attached form to file 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 you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated 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 Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of 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 unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

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. Utilice el formulario adjunto 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 usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da 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 está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

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.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. 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.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

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 serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. 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 puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other 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.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or 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) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

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 website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

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

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (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.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

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, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
   You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* **Orange County Department of Education**
11. Address. *Dirección.* **200 Kalmus Drive, Costa Mesa, CA 92626**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
    York Risk Services Group, Inc., P.O. Box 619079, Roseville, CA 95661
16. Insurance Policy Number. *El número de la póliza de Seguro.* **Self-Insured**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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

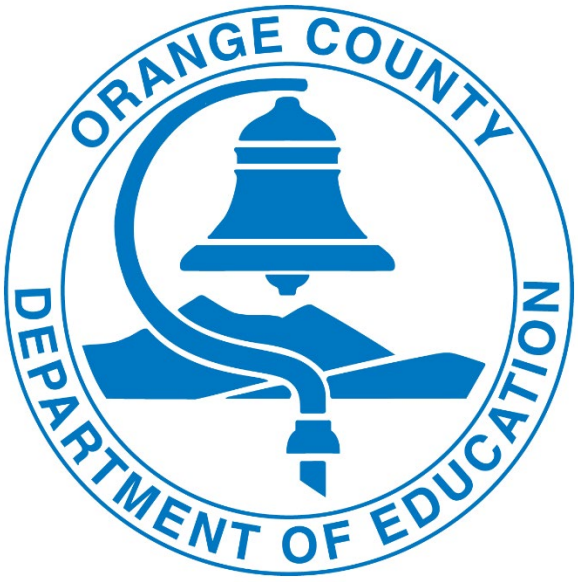
Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma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

Rev. 1/1/2016

Injury and Illness Prevention Program



Appendix 4

Supervisor's Report of Injury Form

ORANGE COUNTY DEPARTMENT OF EDUCATION
SUPERVISOR'S REPORT OF INJURY FORM

1. EMPLOYER
ORANGE COUNTY DEPARTMENT OF EDUCATION

2. NATURE OF BUSINESS
EDUCATION

3. SITE NAME AND ADDRESS (e.g., Kalmus, 200 Kalmus Drive, Costa Mesa, CA 92626)

4. NAME OF INJURED EMPLOYEE

5. SEX ☐ MALE ☐ FEMALE

6. OCCUPATION

7. DEPARTMENT WHERE EMPLOYEE WORKS (e.g., HR, Business Services)

8. SUPERVISOR

9. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (e.g., classroom, office, playground)

10. ON EMPLOYER PREMISES? ☐ YES ☐ NO

11. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (e.g., Welding seams of metal forms, loading boxes onto a truck)

12. HOW DID ACCIDENT OR EXPOSURE OCCUR? (e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld.)

13. OBJECT, EQUIPMENT, OR SUBSTANCE THAT CAUSED THE INJURY TO THE EMPLOYEE (e.g., Acetylene, welding torch, farm tractor, scaffolding)

14. WHAT IS THE INJURY OR ILLNESS, AND WHAT PART OF THE BODY IS AFFECTED? (e.g., Burned right hand)

15. DATE OF INJURY OR ILLNESS
MONTH DAY YEAR

16. TIME OF DAY ☐ A. M. ☐ P. M.

17. DATE INJURY REPORTED TO SUPERVISOR

18. NAME OF SUPERVISOR TO WHOM INJURY WAS REPORTED

19. CLAIM FORM GIVEN TO EMPLOYEE ☐ YES, DATE _____ ☐ NO, EXPLAIN

20. HAS EMPLOYEE RETURNED TO WORK? ☐ YES, DATE RETURNED _____ ☐ NO, STILL OFF WORK

21. WAS FIRST AID TREATMENT ADEQUATE? ☐ YES ☐ NO, EXPLAIN

22. DID EMPLOYEE GO TO THE DOCTOR? ☐ YES ☐ NO

23. NAME OF THE DOCTOR OR CLINIC AND ADDRESS

24. DID AN UNSAFE CONDITION CONTRIBUTE TO THE ACCIDENT? ☐ YES ☐ NO

25. DESCRIBE THE UNSAFE CONDITION (IF APPLICABLE)

26. DID THE EMPLOYEE COMMIT AN UNSAFE ACT? ☐ YES ☐ NO

27. DESCRIBE THE UNSAFE ACT (IF APPLICABLE)

28. PERSONAL FACTORS THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT
☐ IMPROPER ATTITUDE ☐ PERSONAL FACTORS (EYESIGHT, HEARING, FATIGUE, ETC) ☐ OTHER
☐ LACK OF KNOWLEDGE OR SKILL ☐ NO UNSAFE PERSONAL FACTOR

29. AS THE SUPERVISOR, WHAT HAVE YOU PERSONALLY DONE TO PREVENT SIMILAR ACCIDENTS?

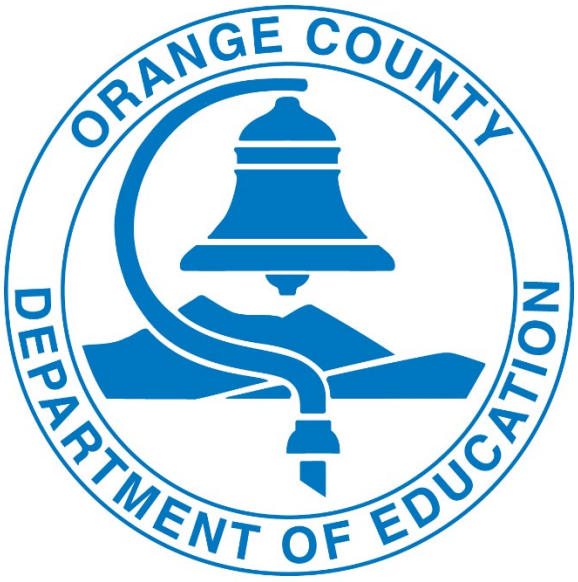
LIST ALL WITNESSES

_____ _____
EMPLOYEE DATE

_____ _____
SUPERVISOR DATE

Revised 06/25/2012

Injury and Illness Prevention Program



Appendix 5

Workers' Compensation Medical Service Order

WORKERS' COMPENSATION
MEDICAL SERVICE ORDER

TO DOCTOR _____

ADDRESS _____

OUR EMPLOYEE _____
(NAME)

reports an injury to the _____
(PART(S) OF BODY INVOLVED)

while _____
(TELL HOW INJURY OCCURRED)

_____

On _____ At _____
(DATE) (TIME)

Please examine and provide medical treatment which may be required as a result of this injury. Send your "Doctor's First Report of Work Injury" to YORK with a copy to our Company. Thank you.

ORANGE COUNTY DEPARTMENT OF EDUCATION
200 KALMUS DRIVE, COSTA MESA, CA 92626
(COMPANY NAME AND ADDRESS)

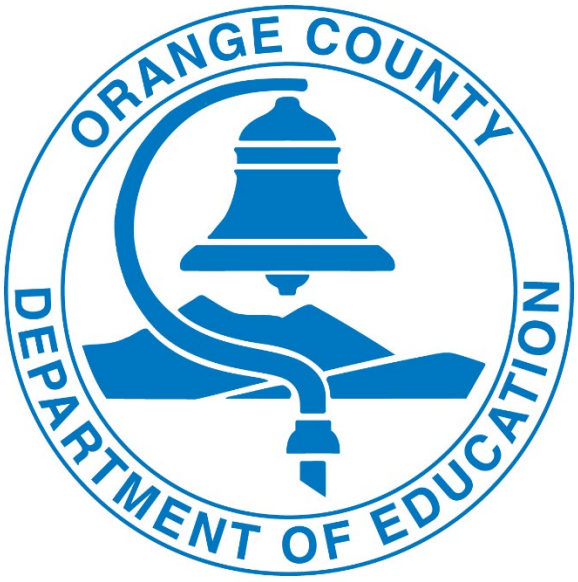
714-966-4059 _____
(PHONE) (SIGNATURE)

_____ _____
(DATE) (TITLE)

YORK RISK SERVICES GROUP, INC. - CA

P.O. BOX 619079
ROSEVILLE, CA 95661
(909) 942-4900

Injury and Illness Prevention Program



Appendix 6

Approved Workers' Compensation Medical Facilities

ORANGE COUNTY DEPARTMENT OF EDUCATION

MEDICAL PANEL FOR EMPLOYEE INJURIES

The following medical facilities are authorized to provide treatment for on-the-job injuries:

Medical Groups

AKESO OCCUPATIONAL HEALTH
17232 Red Hill Ave
Irvine, CA 92614
P: 949.752.1111
F: 949.752.1133

Hours: 8:00 am – 6:00 pm M-F
9:00 am – 3:00 pm Sat

AKESO OCCUPATIONAL HEALTH
17122 Beach Blvd., #104
Huntington Beach, CA 92647
P: 714.964.4448
F: 714.963.3780

Hours: 8:00 am – 6:00 pm M-F
Closed Weekends

CARBON HEALTH
1421 W. MacArthur Blvd., Ste. E
Santa Ana, CA. 92704
P: 714.710.3030
F: 714.668.9596

Hours: 8:00 am – 7:00 pm M-F
9:00 am – 5:00 pm Sat

GATEWAY URGENT CARE
710 North Euclid Street, #107
Anaheim, CA. 92801
P: 714.778.3838
F: 714.778.1962

Hours: Open 24/7

RESTORE ORTHOPEDICS AND SPINE CENTER URGENT CARE
1120 West La Veta Ave., #300
Orange, CA 92868
P: 714-332-5517
F: 714-941-9539

Hours: 8:00 am – 5:00 pm M-F

SAND CANYON URGENT CARE
15775 Laguna Canyon Rd., #100
Irvine, CA. 92618
P: 949.417.0272
F: 949.417.0276

Hours: 8:00 am – 7:00 pm M-F
9:00 am – 5:00 pm Sat
11:00 am – 5:00 pm Sun

SUNRISE HEALTH CARE CENTER
5475 E. La Palma Ave., #100
Anaheim, CA. 92807
P: 714.970.0911
F: 714.970.0604

Hours: 7:00 am – 7:00 pm M-F
9:00 am – 5:00 pm Sat-Sun

XPRESS URGENT CARE
17612 E. 17th Street
Tustin, CA 92780
P: 714.243.5450
F: 714.838-8944

Hours: 8:00 am – 8:00 pm M-F
8:00 am – 8:00 pm Sat- Sun