SDRMA

Workplace Injury Packet

SECTION 2

WWW.SDRMA.ORG

Environmental health and safety requires all employees to be knowledgeable of, and accountable for complying with applicable safety regulations governing specific job duties or activities they are assigned to carry out. Supervisors are responsible for ensuring their employees are informed about and comply with health and safety provisions of the Agency's injury and illness prevention program. This section should help a supervisor determine the severity of the injury of illness. By making employee safety a priority for every employee, we can reduce injuries and illnesses, increase productivity, and promote a safer and healthier environment for all employees.

California Labor Code Section 5401(A)

First aid is defined as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters or other minor industrial injury, which do not ordinarily require medical care".

Non-Recordable Injuries

First-aid injuries need not be recorded if the work-related injury does not involve loss of consciousness, restriction of work or motion, or transfer to another job. NOTE: The administration of a tetanus shot or booster, by itself, is not considered medical treatment. However, injuries requiring tetanus shots may be recordable for other reasons. Injuries or illnesses that are not work-related are not recordable for CAL/OSHA.

First Aid Injuries

- Application of antiseptics during first visit to medical personnel
- Treatment of first-degree burn(s)
- Application of bandage(s) during first visit to medical personnel
- Use of elastic bandage(s) during first visit to medical personnel
- Removal of foreign bodies not embedded in eye, if only irrigation required
- Removal of foreign bodies from wound using simple techniques
- Use of non-prescription medicine
- Soaking therapy on initial visit to medical personnel; or
- Removal of bandages by soaking
- Application of hot or cold compress(es) during first visit
- Application of ointments to abrasions to prevent drying or cracking
- Application of heat therapy during first visit to medical personnel
- Use of whirlpool bath therapy during first visit to medical personnel
- Negative x-ray results
- Brief observation of injury during first visit to medical personnel

Major Injury/Illness

- Chest pain
- Difficulty breathing
- Loss of, or change in, level of consciousness
- Severe burns
- Head or neck injury
- Penetrating wound of chest or abdomen
- Amputation
- Allergic reaction with tightness in throat, difficulty breathing, or dizziness
- Severe bleeding
- Obvious fracture with deformity
- Falls of greater than four feet
- Penetrating eye injuries
- Toxic chemical exposures (swallowing, inhalation, skin contact)
- Multiple injuries
- Psychiatric disturbances (hallucinations, delusions)
- Seizure
- Lacerations (cuts) exceeding two inches in length
- Any injury that results in lost time or restricted duty
- Death due to workplace injury

DECLINING FIRST AID INJURY TREATMENT – INJURY CHECKLIST

An injury or illness has occurred. The injured employee has declined medical treatment. The injured employee or their representative must receive the DWC 1 Form within 24 hours of notification of work related injury or illness.

ALL ITEMS ON THIS PAGE SHOULD BE COMPLETED WITHIN 24 HOURS OF EMPLOYER KNOWLEDGE OF AN EMPLOYEE INJURY OR ILLNESS. CHECK OFF EACH ITEM AS IT IS COMPLETED:

Employee:

- ❑ Call Company Nurse - 877.518.6711
- ❑ Complete the employee portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".
- ❑ Complete the employee portion of the ***Declination of Medical Treatment Form***.
- ❑ Complete the employee portion of the ***Declination of Medical Treatment Incident Report Form***.

Supervisor:

- ❑ Complete the employer portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".
- ❑ Complete the employer portion of the ***Declination of Medical Treatment Form***.
- ❑ Complete the employer portion of the ***Declination of Medical Treatment Incident Report Form***.
- ❑ Complete the ***Supervisor Incident Report Form***.

Distribution of Forms:

- ❑ Employee: Keep a copy of the ***DWC 1 Form*** and mark it "Temporary Receipt" until you receive the signed and dated copy from your employer. Also, keep a copy of the ***Declination of Medical Treatment Form*** and the ***Declination of Medical Treatment Incident Report Form***.
- ❑ Supervisor: Give completed forms to the Workers' Compensation Coordinator immediately.
- ❑ Make copies of the ***Supervisor Incident Report Form*** and give to the appropriate personnel for completion of the OSHA 300 Log and/or initiation of standard Safety investigation procedures in accordance with the Injury and Illness Prevention Program.
- ❑ Mail a copy of the ***Supervisor Incident Report Form*** with indicated attachments to York at:

York Risk Services Group, Inc.
Post Office Box 619079
Roseville, California 95661

Employee: Sign here to acknowledge receipt of the Workplace Injury Packet

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Employee's Signature

SDRMA

Declining First Aid Treatment

SUPERVISOR INCIDENT REPORT FORM

Supervisors use this form for any work related incident or accident.

EMPLOYEE NAME:	GENDER: ❑ M ❑ F	❑ Full Time ❑ Part Time
JOB TITLE:	ENTITY:	
DATE OF HIRE:	DEPARTMENT:	

INVESTIGATION
Interview the Employee and investigate the reported incident and then complete the following:

❑ Check this box if a Declination of Medical Treatment Packet was previously completed for this same incident.

INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (building location, department, etc.):
DATE REPORTED:	TIME BEGAN WORK:	

DESCRIPTION OF INCIDENT - Interview the Employee and any witnesses, and determine how the incident occurred and what the employee was doing prior to incident.

DESCRIPTION OF THE INJURY - Body part injured type of injury, etc.

INJURY SOURCE - Investigate and comment on the source of the injury. For example, if the employee has a laceration caused by a tool, examine the tool and indicate whether is appears to be in proper condition, is properly guarded, etc.

HOW INJURY OCCURRED - Investigate how the injury occurred, and determine whether it was caused by an unsafe act or an unsafe condition, or both. Use the sections below to detail the nature of the act(s) or condition(s) that may have caused or contributed to the incident.

UNSAFE ACT – (IF ANY)		PREVENTIVE ACTION(S) TO BE TAKEN
❑ IMPROPER BODY POSITIONING	❑ UNSAFE WORK METHOD	❑ PROVIDE ADDITIONAL TRAINING
❑ HURRIED OR DISTRACTED WORK	❑ UNSAFE USE OF EQUIPMENT	❑ MODIFY/DISCONTINUE WORK PRACTICE
❑ FAILURE TO USE PROPER PERSONAL	❑ IMPROPER LIFTING TECHNIQUE	❑ OTHER:
❑ PROTECTIVE EQUIPMENT (Specify):	❑ OVEREXERTION	

SUPERVISOR'S SIGNATURE

SUPERVISOR:		TITLE:
SIGNATURE:	DATE:	PHONE:

"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 is guilty of a felony." *This notice approved by the Administrative Director of the Division of Workers' Compensation (CA Labor Code §5401.7)*

Within 7 days of receiving information that a recordable work-related injury or illness has occurred, this form or the Cal/OSHA 301 must be completed.

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." *Reference: Section 14300.29 (b)(6)-(10)*
When a work-connected fatality or hospitalization occurs, The State of California requires the employer to immediately (within 8 hours) contact the local CalOSHA Area Office to report the incident. *Reference: General Industry Safety Orders Section 342 Reporting Work-Connected Fatalities and Serious Injuries*

DECLINATION OF MEDICAL TREATMENT FORM

This form should be completed AFTER calling Company Nurse and it is agreed that the employee does not need (or request) medical treatment.

EMPLOYEE: Check all that apply. Print name, sign and date

- ❑ In my opinion, I am not in need of any medical treatment at this time.

OR

- ❑ In my opinion, I have received sufficient on-site first aid care in the form of:
- ❑ Application of antiseptics
- ❑ Treatment of first-degree burn(s)
- ❑ Application of bandage(s)
- ❑ Use of elastic bandage(s)
- ❑ Removal of foreign bodies not embedded in eye (only irrigation required)
- ❑ Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)
- ❑ Use of nonprescription medications
- ❑ Application of hot or cold compress(es)
- ❑ Application of ointments to abrasions to prevent drying or cracking

EMPLOYEE: I am fully capable of performing my usual and customary position. At this time I decline medical care. If I am in need of medical care related to this incident in the future, I will notify my supervisor immediately and complete an Initial Injury Forms including the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits.

PRINT NAME:	
SIGNATURE:	DATE:

SUPERVISOR: Print name, sign and date.

PRINT NAME:	
SIGNATURE:	DATE:

Note: California Labor Code Section 5401(a) defines a first aid injury as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which does not ordinarily require medical care" and states that any injury that "results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid" must be filed as a claim. All of the treatments detailed above fall under the first aid category; therefore, unless further treatment is necessary, a workers' compensation claim does not need to be filed.

Initial Distribution: Employee / Employee's Workers' Compensation Claim File

DECLINATION OF MEDICAL TREATMENT INCIDENT REPORT FORM

This form should be completed ONLY if the employee does not need (or request medical treatment.

EMPLOYEE COMPLETE TOP PORTION:			
EMPLOYEE NAME:		GENDER: ❑ M ❑ F	❑ Full Time ❑ Part Time
JOB TITLE:		DATE OF HIRE:	
HOME PHONE:		DATE OF BIRTH:	
HOME ADDRESS:		ENTITY:	
		DEPARTMENT:	
INCIDENT DATE:	TIME OF INCIDENT:	LOCATION:	
DATE REPORTED:	TIME BEGAN WORK:	INCIDENT REPORTED TO:	
NATURE OF INJURY (e.g., puncture, strain, cut, fracture, burn, etc.):			
BODY PART INJURED (e.g., right wrist, left knee, head, lower back, etc.):			
INJURY SOURCE (e.g., wet pavement, jack hammer, keyboard, etc.):			
HOW INJURY OCCURRED (struck by ..., fell from ..., exposed to ..., etc.):			
DESCRIBE ANY PREVIOUS CONDITIONS/INJURIES TO BODY PART CURRENTLY INJURED:			
EMPLOYEE'S STATEMENT OF WHAT OCCURRED (Include as much detail as possible such as activity being performed, objects carried, equipment used, hazardous conditions, etc.):			
WHO WITNESSED THE INCIDENT?			
❑ The above information is true and correct to the best of my knowledge. ❑ I understand that I am not filing a Workers' Compensation claim at this time. I do not choose to complete the DWC Form 1 "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my supervisor and complete an Initial Injury Packet including the DWC Form 1.			
EMPLOYEE'S SIGNATURE:		DATE:	
SUPERVISOR COMPLETE BOTTOM PORTION:			
MEDICAL TREATMENT (NOTE: If the Employee needs/requests medical treatment from a physician, complete the initial Injury Packet)			
❑ EMPLOYEE DECLINED MEDICAL TREATMENT ❑ EMPLOYEE RECEIVED MINOR FIRST AID CARE ON-SITE DESCRIBE:			
SUPERVISOR:		TITLE:	
SIGNATURE:	DATE:	PHONE:	

Initiate incident investigation in accordance with the Injury and Illness Prevention Program (IIPP)

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FIRST AID INJURY WITH TREATMENT – INJURY CHECKLIST

An injury or illness has occurred. The injured employee has requested medical treatment. Follow all instructions prior to medical treatment. If the Supervisor takes the Employee to the medical facility, then the forms can be completed there. If there is an emergency call 911 first, and then complete the forms as soon as possible after treatment. The injured employee or their representative must received the DWC 1 Form within 24 hours of notification of work related injury or illness.

ALL ITEMS ON THIS PAGE SHOULD BE COMPLETED WITHIN 24 HOURS OF EMPLOYER KNOWLEDGE OF AN EMPLOYEE INJURY OR ILLNESS. CHECK OFF EACH ITEM AS IT IS COMPLETED:

Employee:

- ❑ Call Company Nurse - 877.518.6711
- ❑ Complete the employee portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".

Supervisor:

- ❑ Complete the employer portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".
- ❑ Complete ***5020 Form*** (Employer's Report of Occupational Injury or Illness). The 5020 Form is also available online at www.sdrma.org.
- ❑ Pull a copy of the employee's usual & customary job description (if available) and provide to Employee.

Distribution of Forms:

- ❑ Employee: Keep a copy of the ***DWC 1 Form*** and mark it "Temporary Receipt" until you receive the signed and dated copy from your employer.
- ❑ Supervisor: Give completed forms to the Workers' Compensation Coordinator immediately.
- ❑ Make copies of the ***Supervisor Incident Report Form*** and give to the appropriate personnel for completion of the OSHA 300 Log and/or initiation of standard Safety investigation procedures in accordance with the Injury and Illness Prevention Program.
- ❑ Mail a copy of the ***Supervisor Incident Report Form*** with indicated attachments to York at:

York Risk Services Group
Post Office Box 619079
Roseville, California 95661

Employee: Sign here to acknowledge receipt of the Workplace Injury Packet

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Employee's Signature

Check to indicate treatment location:

❑ Designated Medical Facility ❑ Pre-designated Physician

SDRMA

First Aid Injury With Treatment

MAJOR INJURY/ILLNESS WITH TREATMENT – INJURY CHECKLIST

An injury or illness has occurred. The injured employee has requested medical treatment. Follow all instructions prior to medical treatment. If the Supervisor takes the Employee to the medical facility, then the forms can be completed there. If there is an emergency call 911 first, and then complete the forms as soon as possible after treatment. The injured employee or their representative must received the DWC 1 Form within 24 hours of notification of work related injury or illness.

ALL ITEMS ON THIS PAGE SHOULD BE COMPLETED WITHIN 24 HOURS OF EMPLOYER KNOWLEDGE OF AN EMPLOYEE INJURY OR ILLNESS. CHECK OFF EACH ITEM AS IT IS COMPLETED:

Employee:

- ❑ Call Company Nurse - 877.518.6711
- ❑ Complete the employee portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".

Supervisor:

- ❑ Complete the employer portion of the ***Department of Workers' Compensation Form (DWC 1)*** "Employee's Claim for Workers' Compensation Benefits".
- ❑ Complete ***5020 Form*** (Employer's Report of Occupational Injury or Illness). The 5020 Form is also available online at www.sdrma.org.
- ❑ Pull a copy of the employee's usual & customary job description (if available) and provide to Employee.

Distribution of Forms:

- ❑ Employee: Keep a copy of the ***DWC 1 Form*** and mark it "Temporary Receipt" until you receive the signed and dated copy from your employer.
- ❑ Supervisor: Give completed forms to the Workers' Compensation Coordinator immediately.
- ❑ Make copies of the ***Supervisor Incident Report Form*** and give to the appropriate personnel for completion of the OSHA 300 Log and/or initiation of standard Safety investigation procedures in accordance with the Injury and Illness Prevention Program.
- ❑ Mail a copy of the ***Supervisor Incident Report Form*** with indicated attachments to York at:

York Risk Services Group
Post Office Box 619079
Roseville, California 95661

Employee: Sign here to acknowledge receipt of the Workplace Injury Packet

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Employee's Signature

Check to indicate treatment location:

❑ Designated Medical Facility ❑ Pre-designated Physician

SDRMA

Major Injury / Illness With Treatment

EMPLOYEE INCIDENT REPORT FORM

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 is guilty of a felony.

(The Administrative Director of the Division of Workers' Compensation (California Labor Code Section 5401.7) has approved this notice).

<table>
<tr><td colspan="2">EMPLOYEE NAME:</td><td>GENDER:
❑ M ❑ F</td><td>❑ Full Time ❑ Part Time</td></tr>
<tr><td colspan="2">JOB TITLE:</td><td colspan="2">DATE OF HIRE:</td></tr>
<tr><td colspan="2">HOME PHONE:</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td colspan="2" rowspan="2">HOME ADDRESS:</td><td colspan="2">ENTITY:</td></tr>
<tr><td colspan="2">DEPARTMENT:</td></tr>
<tr><td>INCIDENT DATE:</td><td>TIME OF INCIDENT:</td><td colspan="2">LOCATION OF INCIDENT:</td></tr>
<tr><td>DATE REPORTED:</td><td>TIME BEGAN WORK:</td><td colspan="2">INCIDENT REPORTED TO:</td></tr>
<tr><td colspan="4">NATURE OF INJURY (e.g., puncture, strain, cut, fracture, burn, etc.):</td></tr>
<tr><td colspan="4">BODY PART INJURED (e.g., right wrist, left knee, head, lower back, etc.):</td></tr>
<tr><td colspan="4">INJURY SOURCE (e.g., wet floor, jack hammer, keyboard, etc.):</td></tr>
<tr><td colspan="4">WHO WITNESSED THE INCIDENT?</td></tr>
<tr><td colspan="3">The information contained in this report is true and correct to the best of my knowledge.
EMPLOYEE'S SIGNATURE:</td><td>DATE:</td></tr>
</table>

Initiate incident investigation in accordance with the Injury and Illness Prevention Program (IIPP)

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