City of San Diego
Parks and Recreation Department

CALL-IN-CENTER PROCEDURES FOR REPORTING WORK RELATED INJURIES TRAINING AGENDA AND CONTENT

1. REVIEW KEY POINTS FROM RISK MANAGEMENT

(a) The goal of this system is reduce notification time between the supervisor and Workers' Compensation Division of Risk Management.

(b) The Call-In-Center has been in place since April 1, 2003.

(c) **The Call-In-Center is for reporting injuries only.** The Call-In-Center staff are not from the City of San Diego and are not available for routine questions. (The City is charged for each phone call!) The Call-In-Center will be staffed 24 hours/day, 7 days/week. Questions contact Risk Management at 619/23-66395.

(d) An injured employee is defined as an employee with an injury requiring medical attention. For minor injuries (requiring first aid only), continue to use the "Report of Minor Injury" (Form RM-1568).

(e) Employee's Claim for Workers' Compensation Benefits (RM-1642) and the Medical Status Report for Occupational Injury or Illness (RM-1534) will be the only forms needed after April 1, 2003. The following forms will no longer be needed after March 31, 2003: Employer's Report of Occupational Injury or Illness (RM-1531A), and Supervisors' Injury Investigation Report (RM-1563).

2. REVIEW THE INJURY REPORTING PROCEDURES

(a) The employee **reports an injury** to the supervisor. The supervisor gives the employee the **Employee's Claim for Workers' Compensation Benefits** form. The employee fills out the top half of the claim form and returns the form to the supervisor. The supervisor fills out the bottom half of the claim form and gives it to the payroll specialist. The payroll specialist routes the claim form to Risk Management.

(b) The **supervisor must call the Call-In-Center at 1-800-427-7980 within 24 hours** of when the employee reports the injury, and provide the following information: Injured Employee's Name and Social Security Number, Date of Injury, Where Injury Happened, Body Part Injured, and How Injury Occurred.

(c) **Risk Management will be notified by the Call-In-Center** within 24 hours of the supervisor's call. A claim is opened and assigned. Risk Management will contact the supervisor, injured employee and physician.

(d) Employee will receive a **Medical Status Report for Occupational Injury or Illness** form from the supervisor, payroll specialist or Sharp Rees-Stealy facility. The employee will complete the top portion of the form. The doctor will complete the work restriction portion. The Employee will give the completed form to the supervisor or payroll specialist. Employee will take a new the Medical Status Report for Occupational Injury or Illness form to the doctor for each visit.

Questions regarding training content, contact the Training Office at 619/52-58245.

THE CITY OF SAN DIEGO

Medical Status Report for Occupational Injury or Illness

INSTRUCTIONS: Employee must submit this form to physician for completion at each medical evaluation. This is not required for each physical therapy visit. Submit completed leave slip to supervisor or department designee after every visit.

EMPLOYEE

PRINT NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	CITY I.D. NUMBER

DEPARTMENT / DIVISION	DATE OF INJURY	REOCCURRENCE OF OLD DISABILITY? ☐YES ☐NO	IMMEDIATE SUPERVISOR	SUPERVISOR PHONE NUMBER

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS

THE FOLLOWING IS AN UPDATE OF MY MEDICAL STATUS IN REGARD TO INDUSTRIAL LEAVE, AND/OR LIGHT DUTY. TO PRESERVE MY BENEFITS UNDER THE APPROPRIATE PROGRAM I WILL SUBMIT A MEDICAL STATUS REPORT EACH TIME I RECEIVE AUTHORIZED MEDICAL TREATMENT.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

X _____ _____ _____
Signature Date Phone

*INDUSTRIAL LEAVE IS SUBJECT TO APPROVAL BY RISK MANAGEMENT IN ACCORDANCE WITH A.R. 63.50.

SAMPLE

PHYSICIAN

TREATING PHYSICIAN	ADDRESS	PHONE

BRIEF PROGNOSIS	DATE OF VISIT	DID INJURY RESULT IN AGG. OF PRE-EXIST. NON-IND. CONDITION? ☐YES ☐NO	WORK RELATED INJURY? ☐YES ☐NO	☐INITIAL VISIT ☐RECHECK ☐FINAL VISIT

☐ RETURN TO REGULAR WORK – EFFECTIVE DATE: _____

☐ RETURN TO WORK WITH FOLLOWING RESTRICTIONS:

- ☐ NO DRIVING OF ANY/COMMERCIAL VEHICLES
- ☐ NO WORKING NEAR MOVING MACHINERY
- ☐ NO PROLONGED SITTING
- ☐ NO PROLONGED STANDING AND WALKING
- ☐ ELEVATE INJURED EXTREMITY TO DECREASE SWELLING
- ☐ SITTING WORK ONLY
- ☐ NO KNEELING OR SQUATTING
- ☐ NO REPETITIVE CLIMBING, BENDING OR TWISTING
- ☐ WEIGHT LIFTING RESTRICTIONS _____ LBS.
- ☐ SEDENTARY WORK ONLY
- ☐ LIMITED USE OF RIGHT/LEFT HAND/UPPER EXTREMITY
- ☐ LIMITED PUSHING/PULLING/GRASPING OF RIGHT/LEFT HAND
- ☐ REPETITIVE HAND/WRIST WORK LIMITED TO _____
- ☐ KEYBOARD WORK LIMITED TO _____
- ☐ CAN WORK IN SPLINT/SUPPORT ONLY/AS NEEDED
- ☐ HAND/NECK/BACK STRETCHING BREAKS FOR _____
- ☐ ROTATE JOB TASKS TO MINIMIZE CONTINUOUS REPETITIVE HAND/WRIST MOTION
- ☐ NO OVERHEAD LIFTING OR REACHING WITH RIGHT/LEFT UPPER EXTREMITY
- ☐ NO OVERHEAD WORK
- ☐ AVOID PROLONGED NECK FLEXED/EXTENDED POSTURE
- ☐ _____
- ☐ _____

☐ UNABLE TO PERFORM ANY WORK ACTIVITIES AT THIS TIME. EST. DURATION: _____

NEXT APPT. DATE _____ PHYS. SIGNATURE _____ TIME IN _____ TIME OUT _____

PHYSICAL THERAPY

PHYSICAL THERAPY FACILITY _____

DATE _____	TIME IN _____	TIME OUT _____	DATE _____	TIME IN _____	TIME OUT _____
DATE _____	TIME IN _____	TIME OUT _____	DATE _____	TIME IN _____	TIME OUT _____
DATE _____	TIME IN _____	TIME OUT _____	DATE _____	TIME IN _____	TIME OUT _____

DEPARTMENT

LIGHT DUTY ☐ IS ☐ IS NOT AVAILABLE AT THIS TIME. ASSIGNMENT: DEPT./DIV. _____

WORK LOCATION _____ SUPERVISOR _____ PHONE _____

_____
Light Duty Coordinator Date

PAYROLL

INC. DATES OF ABSENCE: FIRST DATE _____ LAST DATE _____ # OF HRS. ABSENT _____

RECOMMEND: ☐ APPROVED ☐ DISAPPROVED ☐ PENDING

_____
Division Head / Designee

RM-1634 (12-02) 593269

WHITE: RISK MANAGEMENT CANARY: DEPARTMENT PINK: EMPLOYEE

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

CITY OF SAN DIEGO
RISK MANAGEMENT DEPARTMENT
1200 3RD AVENUE, SUITE 1000
SAN DIEGO, CA 92101, M.S. 51B
(619) 236-6395

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the **"Employee"** section and give the form to your employer. Keep the copy marked **"Employee's Temporary Receipt"** until you receive the dated copy from your employer. You may call the Division of Worker's Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

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

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.

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

*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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401**. En la parte de atrás de esta forma se encuentra una 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.

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: *Empleado:*

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 donde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer — complete this section and give the employee a copy immediately as a receipt.
Empleador — complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que 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.* _____
15. Insurance Policy Number. *El número de la póliza del Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

ORIGINAL (Employer's Copy)
DWC Form 1 (REV. 1/94)
RM-1642 (2-94)
593267

ORIGINAL (Copia del Empleador)
DWC Forma 1 (REV. 1/94)