

FILING INJURY/ILLNESS AND RETURN TO WORK FORMS FOR SANTA CRUZ COUNTY VOLUNTEER FIREFIGHTERS

Contacts for Workers Compensation Claim Reporting and Documentation

Santa Cruz County Fire Analyst: Melissa Scalia
P.O. Drawer F-2, Felton, CA 95018
Phone: 831-335-6734
Confidential FAX: (831) 335-6714

Company Officer: _____

Battalion Chief: _____

1. PROVIDENT FIRST NOTICE OF CLAIM

PBG-CL-008-MUL-0714 (07-2014)

1. Volunteer must complete, sign, and submit form.
2. Battalion Chief must review and sign.
3. Write "Santa Cruz County Fire" on the top of the form.
4. Fax Immediately to the Confidential FAX at: (831) 335-6714.
5. Mail a hard copy to the County Fire Analyst
6. Send original to Provident

2. FORM 5020

*State of California Employer's
Report of Occupational Injury or Illness*

1. Battalion Chief, not Volunteer, must complete, sign, and submit form.
2. Write "Santa Cruz County Fire" on the top of the form.
3. Fax Immediately to Confidential FAX at: (831) 335-6714.
4. Mail a hard copy to the County Fire Analyst

3. SCIF 3301/DWC FORM 1

*State of California Employee's Claim for
Workers' Compensations Benefits*

1. Volunteer and Battalion Chief must complete, sign, and submit form.
2. Write "Santa Cruz County Fire" on the top of the form.
3. Fax Immediately to the Confidential FAX at: (831) 335-6714.
4. Mail a hard copy to the County Fire Analyst

4. DWC-1 DECLINATION FORM

1. Battalion Chief and Volunteer must complete, sign, and submit form ***if Volunteer refuses*** a copy of the DWC 1 form.

5. COUNTY FIRE MEDICAL TREATMENT RETURN TO WORK FORM

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6. COUNTY FIRE PHYSICAL AND MENTAL STRESS JOB DESCRIPTION

- **Battalion Chief gives Volunteer:**
 1. County Fire Medical Treatment/Return to Work
 2. Physical and Mental Stress Job Description
- **Volunteer gives Physician:**
 1. County Fire Medical Treatment/Return to Work.
 2. Physical and Mental Stress Job Description
 3. Physician identifies work status and/or restrictions.
 4. Physician MUST sign and date both forms
 5. Have the Physician indicate "Workers Compensation" on any prescriptions given.
- **Volunteer then gives the Battalion Chief the following forms, signed by Physician.**
 1. County Fire Medical Treatment/Return to Work.
 2. Physical/Mental Stress Job Description.
 3. Volunteer immediately faxes both forms to Confidential FAX at: (831) 335-6714.
 4. ***AFTER EACH DOCTORS VISIT:*** The Volunteer must immediately fax and then mail hard copies of the County Fire Medical Return to Work Form to the County Fire Analyst.
 5. This process continues until the physician either releases the Volunteer to Full Duty or declares the Volunteer unable to return to work in any capacity.

It is imperative that you stay in contact with your Company Officer, Battalion Chief, and County Fire Analyst throughout this process to ensure that all claims are processed in accordance with California Workers Compensation regulations.



Important Notice Regarding Fraud

- ❖ ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the District of Columbia: WARNING:*** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ❖ ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ❖ ***For residents of Maine, Tennessee, Virginia and Washington:***
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ❖ ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ❖ ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ❖ ***For residents of Oklahoma: WARNING:*** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ❖ ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



PROVIDENT
Insuring America's Heroes Since 1928

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
 272 ALPHA DRIVE - P.O. BOX 11588
 PITTSBURGH, PA 15238
 TOLL-FREE: 800-447-0360
 PHONE: 412-963-1200
 CLAIMS DEPT FAX: 412-963-0148
www.providentbenefits.com

*** BOTH SECTIONS MUST BE COMPLETED ***

Name		Date of Birth / /	Social Security Number
Address		City	State Zip Code
Email Address		Home Phone Number ()	
What is your regular, full time occupation?		Employed By (Name of Company)	
Employer's Address		City	State Zip Code
Employer's Phone Number ()		Date of Hire (Full Time Occupation) / /	
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).		Wages/Earnings Hourly: Weekly:	Date of Hire (Full Time Occupation) / /
Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Accident / /	Place of Accident	Date Last Worked / /
What is your injury or illness?		How did it happen?	
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time		Did you file with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I was totally disabled from / / to / /			
I was partially disabled from / / to / /			
Date you have or are expected to return to work / /			

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY. THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

<input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was a member of your organization at the time of injury or illness		Policy Number
<input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was engaged in an authorized activity at the time of injury or illness		
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality
Print Name and Title	Signed	Date / /
Address	City	State Zip Code
Telephone Number ()		
Is the claimant a <input type="checkbox"/> Volunteer <input type="checkbox"/> Career <input type="checkbox"/> PT employee <input type="checkbox"/> Auxiliary <input type="checkbox"/> Other		

See Fraud Warning Important Notice sheet attached.



Provident Agency, Inc. - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800-447-0360 Fax: 412-963-0148

NOTE: This authorization allows the _____ to release all information pertaining to an injury that occurred on or about _____ to Provident Agency, Inc. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits including Social Security benefits, to disclose any and all of this information to persons who administer claims for Provident. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Provident obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Provident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above. I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Claimant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.



DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)

Provident Agency, Inc.; 272 Alpha Drive; P.O. Box 11588

Pittsburgh, PA 15238

Phone: 800.447.0360 Fax: 412.963-0148

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.



I authorize _____ to release information from the record of:

Name of Facility/Person

_____/_____/_____ to

Patient Name

Birth Date

SS # / MR #

_____/_____/_____

Name of Facility/Person

Phone

Fax

_____/_____

Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): _____

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):

Inpatient

Emergency Department

Dates: _____

to _____

Outpatient

Physician Office/Clinic

I authorize the release of: (check all that apply) Mental Health Information Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

Consults

Medical History & Physical Exam

Physician Orders

Discharge Summary/Instructions

Medication Records

Progress Notes

Laboratory Reports/Tests

Operative Report

Psychiatric/Psychological Eval

Mammography Reports

Pathology Report

Radiology Report

Emergency Dept. Reports

EKG Report (s)

Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature

Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature

Signature of Authorized Representative

N/A

Parent or Legal Guardian

Power of Attorney

Next of Kin of Deceased

Executor of Estate

Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date

Witness # 1

Date

Witness # 2

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 <input type="checkbox"/>		
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.				
EMPLOYER	1. FIRM NAME			1a. Policy Number		Please do not use this column
	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		OWNERSHIP
	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 <input type="checkbox"/> Other Gov't, Specify: _____						INDUSTRY
7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		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						AGE
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						DAILY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.						DAYS PER WEEK
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						WEEKLY HOURS
						WEEKLY WAGE
						COUNTY
						NATURE OF INJURY
						PART OF BODY
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*.						SOURCE
						EVENT
						SECONDARY SOURCE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)						
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours			37a. EMPLOYMENT STATUS regular, full-time part-time temporary seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED	
38. GROSS WAGES/SALARY \$ _____ per _____						EXTENT OF INJURY
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No						
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.						



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, el 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 arriesga 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 estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no 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- SJDDB): 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 curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisitos, 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 Estatal de 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.



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.

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

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

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

Employee—complete this section and see note above

Empleado—complete esta sección y note la notación arriba.

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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



*Santa Cruz County Fire Agencies
Insurance Group*

RECEIPT

RECEIPT OF WORKER'S COMPENSATION CLAIM FORM (DWC-1)

Supervisor and employee complete this form IF employee declines to complete/file DWC-1 Form
Ensure that the employee retains the DWC-1 Form

Employee's Name (print) _____

Fire District Santa Cruz County Fire Department

Injury Occurred Date: _____ Time: _____

Nature of Injury _____

Place Injury Occurred _____

Employee Reported Injury Date: _____ Time: _____

Claim Form (DWC-1)
Offered to Employee Date: _____ Time: _____

Employee's Signature _____

Supervisor Completing Form (print) Name: _____

Date: _____ Time: _____



PHYSICAL AND MENTAL STRESS JOB DESCRIPTION

VOLUNTEER FIREFIGHTER (also applies to Volunteer Driver, Engineer, and Captain)

A DESCRIPTION IS GIVEN BELOW OF THE PHYSICAL AND MENTAL STRESSES TO WHICH A VOLUNTEER FIREFIGHTER IS SUBJECTED TO AT CAL FIRE/COUNTY FIRE. YOUR JUDGMENT IS NEEDED AS TO THE APPLICANT'S CAPACITY TO PERFORM THE REQUIRED DUTIES. IN YOUR CONCLUSION, TAKE INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE AND THE APPLICANT'S ABILITY TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.

The Volunteer Firefighter is a member of a fire crew and works under the general supervision of career Battalion Chiefs through the chain of command to perform the full range of firefighting duties in suppression of vehicle, building and vegetation fires.

Specifically, the Volunteer Firefighter responds to alarms as a member of a fire crew on such fire apparatus as engines, water tenders and squad/rescue vehicles; connects, lays, and operates hose lines; enters burning areas and structures with charged hose lines; uses hand tools and fire equipment to contain and suppress fire. The individual, as a crew member of a rescue unit, assists in Emergency Medical Service, response rescue, and salvage operations. Also assists in performing fire prevention inspections; assists in equipment maintenance and repair; inspects, cleans and repairs fire hose and equipment, sharpens fire tools; may operate motor vehicles in emergency and non-emergency situations; may assist in the training of other fire personnel.

The Volunteer Firefighter must have the ability to read and write English at a level for successful job performance; learn to operate fire apparatus and special fire suppression equipment efficiently and safely; do heavy physical work; follow oral and written directions; write legibly; exercise good judgment in hazardous fire suppression activity; analyze situations accurately and take effective action; work compatibly with others, and be able to work in situations where heat is intense; in addition, to tolerate heavy smoke, dust and exposure environments.

The individual must possess: visual acuity (Snellen) of not less than 20/100 without correction in each eye corrected to not less than 20/30 in one eye; color vision sufficient to discriminate between electrical cable and pipe color coding, and color vision sufficient to correctly identify vehicle colors; hearing adequacy within speech frequency (uncorrected); normal use of both hands and both feet; physical strength and agility; weight in proportion to height; no more than mildly susceptible to poison oak.

CATEGORY I - ARDUOUS PHYSICAL WORK

Duties involve field work requiring physical performance calling for above-average ability, endurance, and superior condition, including occasional demand for extraordinarily strenuous activities in emergencies, under adverse environmental conditions and over extended periods of time; requires running, walking, difficult climbing, jumping, twisting, bending and lifting over 25 pounds; and the pace of work is typically set by the emergency situation.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE CAL FIRE/COUNTY FIRE PHYSICAL/MENTAL STRESS JOB DESCRIPTION FOR THE EMPLOYEE NAMED BELOW AND THAT IN HIS/HER JUDGMENT THE EMPLOYEE HAS THE CAPACITY TO PERFORM THE REQUIRED DUTIES, HAS TAKEN INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE, AND THE EMPLOYEE IS ABLE TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.	
VOLUNTEER NAME (PRINT)	WORK UNIT Santa Cruz County Fire Department
MEDICAL PROVIDER'S NAME (PRINT)	DATE
MEDICAL PROVIDER'S SIGNATURE	
ADDRESS (PRINT)	
TELEPHONE	



PHYSICAL AND MENTAL STRESS JOB DESCRIPTION

VOLUNTEER EMERGENCY MEDICAL SERVICES RESPONDER (EMR)

A DESCRIPTION IS GIVEN BELOW OF THE PHYSICAL AND MENTAL STRESSES TO WHICH A VOLUNTEER FIREFIGHTER IS SUBJECTED TO AT CAL FIRE/COUNTY FIRE. YOUR JUDGMENT IS NEEDED AS TO THE APPLICANT’S CAPACITY TO PERFORM THE REQUIRED DUTIES. IN YOUR CONCLUSION, TAKE INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE AND THE APPLICANT’S ABILITY TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.

The Volunteer EMR is a member of a volunteer fire company and works under the general supervision of career Battalion Chiefs through the chain of command to provide response to emergency medical incidents and limited support functions to non-medical emergencies.

The EMR is assigned to either an urban or rural area and must have endurance to respond and perform a variety of duties including, but not limited to: prevention and education programs, fundraising activities, company administrative assignments, station maintenance, assistance with rehabilitation of firefighters at fire scenes, assistance with personnel accountability and traffic control at fire scenes. The EMR responds to medical aid calls and provides medical care including CPR.

The Volunteer EMR must have the ability to read and write English at a level for successful job performance; follow oral and written directions; write legibly; exercise good judgment in hazardous environments; analyze situations accurately and take effective action; work compatibly with others.

The individual must possess visual acuity (Snellen) of not less than 20/100 without correction in each eye corrected to not less than 20/30 in one eye; and color vision sufficient to correctly identify vehicle colors; hearing adequacy within speech frequency (uncorrected); normal use of both hands and both feet; physical strength and agility; weight in proportion to height.

Duties involve field work requiring physical performance calling for average ability requiring walking, twisting, bending, and lifting over 25 pounds; and the pace of work is typically set by the emergency situation.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE CAL FIRE/COUNTY FIRE PHYSICAL/MENTAL STRESS JOB DESCRIPTION FOR THE EMPLOYEE NAMED BELOW AND THAT IN HIS/HER JUDGMENT THE EMPLOYEE HAS THE CAPACITY TO PERFORM THE REQUIRED DUTIES, HAS TAKEN INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE, AND THE EMPLOYEE IS ABLE TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.

VOLUNTEER NAME (PRINT)	WORK UNIT Santa Cruz County Fire Department
MEDICAL PROVIDER’S NAME (PRINT)	DATE
MEDICAL PROVIDER’S SIGNATURE	
ADDRESS (PRINT)	
TELEPHONE	

ACKNOWLEDGEMENT OF RECEIPT OF CLAIM FORM

I acknowledge receipt of a Volunteer Claim for Workers' Compensation Benefits

(Form DWC-1) from: _____
Volunteer Name

on _____ at _____
Date Time

Company Officer or Battalion Chief

Signature of Volunteer

Pre-designation Of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury/illness by your personal medical doctor (M.D) or doctor of osteopathic medicine (D.O.) or medical group if: You have health care insurance for injuries/illness that are not work related, the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records; your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries; prior to the injury your doctor agrees to treat you for work injuries or illnesses; prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury/illness, and (2) your personal doctor's name and business address.

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work-related injury/illness and the above requirements are met.

Notice Of Pre-designation Of Personal Physician

Employee: Complete this section

Employer Santa Cruz County Fire Department

If I have a work-related injury or illness, I choose to be treated by:

(Name of doctor) (M.D., D.O., or medical group)

(street address, city, state, zip)

(telephone number)

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee Signature: _____ Date _____

Note to Employee: Unless you agree in writing, neither your employer or Sedgwick may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or Sedgwick may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature _____

Employee # _____ Date _____

Physician: I agree to this Pre-designation:

Signature: _____ Date _____

(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3). (Optional DWC Form 9783 July 1, 2014)

Notice Of Personal Chiropractic Or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.A.C.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.A.C. in writing prior to the injury/illness. Sedgwick generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or Sedgwick has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.A.C. You may use this form to notify your employer of your personal D.C. or L.A.C., or your employer may have their own form. The D.C. or L.A.C. must be your regular D.C. or L.A.C. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.A.C. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

Name of chiropractor or acupuncturist (D.C., L.A.C.)

(street address, city, state, zip code)

(telephone number)

Employee Name (Please Print): _____

Employee's Address: _____

Employee's Signature: _____

Date: _____

Title 8, California Code of Regulations, section 9783.1
(Optional DWC Form 9783.1 Effective date July 1, 2014)

WHEN A WORK INJURY OCCURS...

- **Quickly seek first aid.**
- **Call 9-1-1 for help immediately if emergency medical care is needed.**
- **Immediately report injuries to your supervisor or employer representative at _____**

Information & Assistance Office: _____

Employer MUST complete this information



The Facts About Workers' Compensation

Phone (866) 221-2402
Fax (866) 548-2637

What is workers' compensation? Its purpose is to insure that an employee who is found to sustain an industrial injury or illness will be provided with benefits to medically cure or relieve them from the effects of the injury/illness, provide temporary compensation when they are medically unable to perform any occupational function, compensation for any residual handicap and/or impairment of bodily function, benefits for dependents if an employee dies as a result of an injury/illness, protection from discrimination by his/her employer because of the injury/illness.

Am I Covered? Nearly every person employed in California is protected by workers' compensation, however there are a few exceptions. People that are self-employed or volunteer workers may not be covered. Similar laws cover federal and maritime workers. Sedgwick is your employer's claims administrator. Your employer or Sedgwick can answer any questions you might have about coverage.

What Does Workers' Compensation Cover? If you have an injury/illness due to your job, it is covered. The cause can be a single event, like a fall or it can be due to repeated exposures, such as hearing loss due to constant loud noise. Injuries ranging from first-aid to serious accidents are covered. Even injuries related to a workplace crime, such as psychological or physical injuries, are covered under workers' compensation. Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered. Check with your employer or Sedgwick if you have questions. Coverage begins the moment you start your job. There is no probationary period or wage rate.

Duty Of The Employee. Immediately notify your employer or Sedgwick so you can get the medical help that you need without delay. If your injury is greater than a first-aid injury, your supervisor will give you a Claim Form (Form DWC-1) for you to describe where, when and how it happened. To submit a claim, fill out the "Employee" section of the DWC-1. Keep one copy of this form and give the remaining pages to your supervisor. Your employer will fill out the "Employer" section and return a signed and dated copy of the form to you. Your employer will keep a copy of this form and forward another to Sedgwick. Sedgwick is in charge of handling your claim and informing you about your eligibility for benefits.

Your claim benefits do not start until your employer knows about your injury, so report and file the DWC-1 as quickly as possible. California law requires your employer to authorize medical treatment within one working day of receipt of your Claim Form. Employers are liable for up to \$10,000 in treatment pending a decision by Sedgwick for a claim to be accepted or rejected. Waiting to report may delay workers' compensation benefits. You may not receive benefits if you fail to file a claim within one year of the date of injury, the date you know the injury was work related, or the date benefits were last provided.

Duty of the Employer: Provide this form to every employee at the time of hire or by the end of their first pay period.

Within one working day, upon knowledge or notice from any source of a work injury/illness greater than first-aid, provide the employee with a Claim Form (DWC-1) and authorize medical treatment and report the claim to Sedgwick.

What are the benefits? You may be entitled to various kinds of benefits under California workers' compensation law including:

Medical Care: Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury/illness. There is no deductible or co-payment. These medical benefits may include lab tests, physical therapy, hospital services, medication and treatment by a doctor.

State law limits certain medical services as of January 1, 2004. You should never receive a medical bill. If additional treatment is necessary, Sedgwick will coordinate medical care that meets applicable treatment guidelines for the injury. The doctor may be a specialist for your specific type of injury, and he or she will be familiar with workers' compensation requirements and will report promptly to Sedgwick so your benefits can be paid.

The physician with overall responsibility for treating your injury/illness is your primary treating physician (PTP). The PTP decides what kind of medical care you need and if you have work restrictions. If necessary, the PTP will review your job description with you and your employer to define any limitation or restrictions that you may have. This doctor also is responsible for coordinating care between other medical providers and will write reports about any permanent impairment of bodily function(s) or the need for future medical care. Generally, your employer selects the PTP you will see for the first 30 days, but if you want to change doctors for any reason, ask your employer or Sedgwick. They're as interested as you are in your prompt recovery and return to work and will select a different doctor for you. If your employer has a Medical Provider Network (MPN) you will be directed to treat with a physician within the MPN and different rules apply regarding changing your physician.

You can be treated by your personal physician or medical group immediately if you have health care insurance for injuries or illness that are not work related, and your physician agrees in advance to treat you for any work injuries/illnesses and has previously directed your treatment and retains your medical records and agrees, prior to your injury/illness, to treat you for workplace injuries/illnesses and you gave your employer your physician's name and address in writing before the injury. You may use the form inside of this pamphlet or your employer may have a form for you to use.

If you give the name of your personal chiropractor or acupuncturist, different rules apply, and you may need to see an employer-selected physician first.

Temporary Disability Benefits: If you are not medically able to work for more than three days due to your work-related injury, counting weekends, you have a right to temporary disability (TD) payments to assist substituting your lost wages. After two weeks from reporting the injury, you will receive a check. If your employer has a salary continuation plan, your benefit may be included in your regular paycheck. TD is payable every 14 days until the doctor states you can return to work (Payments won't be made for the first three days, though, unless you're hospitalized as an inpatient or unable to work more than 14 days). The amount of the payments will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. Although the TD payment will not be the full amount of your regular paycheck, there are no deductions and the payments are tax-free. For injuries occurring on or after January 1, 2008, TD payments are limited to 104 compensable weeks within five years of date of injury. For a few long-term injuries such as chronic lung disease or severe burns, TD payments can last up to 240 weeks within five years from the date of injury. If you reach the maximum TD payment period before you can return to work or before your condition becomes permanent and stationary. See the "Other Benefits" section of this pamphlet for additional information. A timely filing with Employment Development Department may result in additional State Disability benefits when TD benefits are delayed, denied, or terminated.

Permanent Disability: If your doctor says your injury will always leave you with some permanent impairment of bodily function(s), you may receive permanent disability (PD) payments. The amount depends on the doctor's report, how much of the PD was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. State law determines minimum and maximum amounts, and they vary by injury date. If you are entitled to PD,

Sedgwick will send you a letter explaining how the benefit was calculated. If the injury causes PD, the first payment of PD benefits is made within 14 days after the last payment of TD, unless your employer has offered you a position that pays at least 85% of your date of injury wages or if you are returned to a position that pays you 100% of the wages and, compensation paid to you on the date of injury, the PD would be paid after an Award issues.

Supplemental Job Displacement Benefit (SJDB): If you have a permanent whole person impairment, the eligibility for SJDB begins when your employer does not offer regular work, permanent, modified, or alternative work within 60 days of the receipt of a doctor's Medical Maximum Improvement (MMI) report. This is a nontransferable voucher for education-related retraining and/or skill development at state-approved schools, tools, licensing, certification fees and other resources as possible benefits. If you qualify for the supplemental job displacement benefit, Sedgwick will provide a voucher up to a maximum of \$6,000.

Death Benefits: If the injury/illness causes death, payments may be made to your dependents. State law sets these benefits and the total benefit depends on the number of dependents. The payments are made at the same rate as TD payments. In addition, workers' compensation provides a burial allowance.

Discrimination: It is a violation of Labor Code Section 132(a) and illegal for your employer to punish or fire you for having a workplace injury/illness, for filing a claim or for testifying in another person's workers' compensation case. If your employer is found guilty of discrimination, you would be entitled to increased benefits, reinstatement and reimbursement for lost wages and benefits.

Other Benefits: Sometimes people confuse workers' compensation with State Disability Insurance (SDI). Workers' compensation covers on-the-job injuries/illnesses and is paid for by your employer or their insurance. On the other hand, SDI covers off-the-job injuries or sicknesses, and is paid for by deductions from your paycheck. If you are not getting workers' compensation benefits, you may be able to get State Disability benefits. Contact the local office of the State Employment Development Department listed in the government pages of your phone book for more information.

You may be eligible to access the return-to-work fund, for the purposes of making supplemental payments to injured worker's whose PD benefits are disproportionately low in comparison to their earnings loss. If you have questions or think you qualify, contact the Information & Assistance office listed in this pamphlet or visit the DIR website at: www.dir.ca.gov.

If You Still Have Questions...ask your supervisor or employer representative. Or contact Sedgwick at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. These officers are available to review problems, answer questions and provide additional written information about workers' compensation at no charge. The local office is listed below and posted at your workplace. You can also call 800-736-7401 or visit the DWC website at: <http://www.dir.ca.gov/dwc>.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Fines can be up to \$150,000 and imprisonment up to five years.



Fax

(Submit within 24 hours of injury)

To: **Santa Cruz County Analyst** Fax: **(831) 335-6714**

Re: **County Fire Injury Reporting** Date:

From: Phone:

Pages:

Urgent For Review Please Comment Please Reply Please Recycle
