



SUPERVISOR INSTRUCTIONS FOR MANAGING INJURED WORKERS

1. IN THE EVENT OF A LIFE THREATENING EMERGENCY, IMMEDIATELY CONTACT:

VALLEY COLLEGE	X 4491
CRAFTON HILLS COLLEGE	X 3275
DISTRICT/ANNEX/ETC/ARF	X 911
PROF. DEVELOPMENT BLDG	

*2. FOR ALL OTHER INJURIES NOT REQUIRING IMMEDIATE EMERGENCY MEDICAL ATTENTION, YOU OR THE EMPLOYEE NEED TO CONTACT THE **COMPANY NURSE INJURY HOTLINE** (1-877-518-6702). COMPANY NURSE GATHERS INFORMATION OVER THE PHONE AND HELPS INJURED WORKER ACCESS APPROPRIATE MEDICAL TREATMENT.*

*3. CONTACT THE HUMAN RESOURCES OFFICE AT **909-382-4040** TO INITIATE THE PROCESS*

CAL-OSHA IS TO BE CONTACTED WITHIN 8 HOURS OF THE EMPLOYERS KNOWLEDGE OF AN EMPLOYEE BEING HOSPITALIZED OR SEVERELY INJURED. IF NOTIFICATION IS NECESSARY ON THE WEEKEND, YOU MUST CONTACT THEM BY CALLING 909-383-4321.

4. PROVIDE THE EMPLOYEE THE FOLLOWING PAPERWORK:

➤ **COVERED EMPLOYEE NOTIFICATIONS OF RIGHTS MATERIALS (MPN)**

➤ **EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS**

- THIS IS AN INTERNAL FORM THAT MUST BE FILLED OUT BY THE EMPLOYEE ANYTIME YOU ARE NOTIFIED THAT AN INJURY, ILLNESS OR ACCIDENT OCCURRED, REGARDLESS OF THE EMPLOYEE'S INTENT TO SEEK MEDICAL CARE. THE EMPLOYEE MUST FILL OUT THIS FORM IMMEDIATELY.

➤ **WORKERS COMPENSATION CLAIM FORM (DWC-1)**

- COMPLETE EMPLOYEE NAME AND NUMBERS 9-17 ON THE FORM
 - THE FOLLOWING INFORMATION SHOULD BE USED FOR ITEMS 14 AND 15:
 - (14) KEENAN & ASSOCIATES; PO BOX 59916; RIVERSIDE CA 92517
 - (15) INSURANCE POLICY NUMBER: NOT APPLICABLE
- IT IS EXTREMELY IMPORTANT FOR THE EMPLOYEE TO RETURN THE DWC-1 FORM AS SOON AS POSSIBLE IN ORDER TO RECEIVE BENEFITS TIMELY
 - IF THE EMPLOYEE DOES NOT WANT TO FILE A CLAIM, GIVE THE EMPLOYEE
 - A COPY OF THE FORM AND SEND THE ORIGINAL TO HUMAN RESOURCES

- IF THE EMPLOYEE DOES WANT TO OPEN A CLAIM, HAVE THEM FILL OUT
 - THE TOP SECTION BEFORE COPYING THE FORM. GIVE THE EMPLOYEE A COPY OF THE FORM. SEND THE ORIGINAL TO HUMAN RESOURCES.

➤ ***AUTHORIZATIONS FOR MEDICAL TREATMENT***

- THE EMPLOYEE SHOULD COMPLETE THE TOP SECTION AND CHECK THE APPROPRIATE BOXES REGARDING MEDICAL TREATMENT.
- MAKE SURE TO PRINT YOUR NAME AND TITLE, AND SIGN THE FORM TO AUTHORIZE TREATMENT.
- FOLLOW THE DISTRIBUTION INSTRUCTIONS ON THE BOTTOM OF THIS FORM AND ENSURE THE EMPLOYEE HAS RECEIVED ALL THE LISTED FORMS.

5. FILL OUT THE ***SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***.

6. PROVIDE THE ***WITNESS REPORT OF INJURY*** TO ANY IDENTIFIED WITNESSES. THIS FORM SHOULD BE FILLED OUT IMMEDIATELY BY THE WITNESS AND RETURNED TO HR. **DO NOT ALLOW THE WITNESSES TO TALK ABOUT THE EVENT BEFORE FILLING OUT THE FORM.**

7. **EMAIL** ALL OF THE FORMS TO THE HUMAN RESOURCES OFFICE IMMEDIATELY AND **MAIL** THE ORIGINAL FORMS TO THE HUMAN RESOURCES OFFICE WITHIN 24 HOURS. THE FORMS THAT SHOULD BE INCLUDED ARE:

- ***EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***
- ***SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***
- ***WORKERS COMPENSATION CLAIM FORM (DWC-1)***
- ***AUTHORIZATION FOR MEDICAL TREATMENT***
- ***WITNESS REPORT OF INJURY (IF APPLICABLE)***

8. THE DISTRICT DOES HAVE A RETURN TO WORK PROGRAM AND SUPERVISORS MAY BE ASKED TO PARTICIPATE IN DISCUSSIONS REGARDING TEMPORARY MODIFIED DUTY

NOTES:

- ANY DOCTOR'S NOTES, APPOINTMENTS NOTICES, OR TEMPORARY/MODIFIED DUTY SLIPS RECEIVED AT THE SITE MUST BE FORWARDED TO THE HUMAN RESOURCES OFFICE IMMEDIATELY
- ANY MODIFIED DUTY REQUIRES COORDINATION WITH HUMAN RESOURCES BEFORE THE
- EMPLOYEE MAY RETURN TO WORK
- PLEASE MARK WORK REPORTS ACCORDINGLY IF THE EMPLOYEE IS OUT FOR ANY INDUSTRIAL INJURY REASONS

IF YOU HAVE ANY QUESTIONS, CONTACT HUMAN RESOURCES AT 909-382-4040