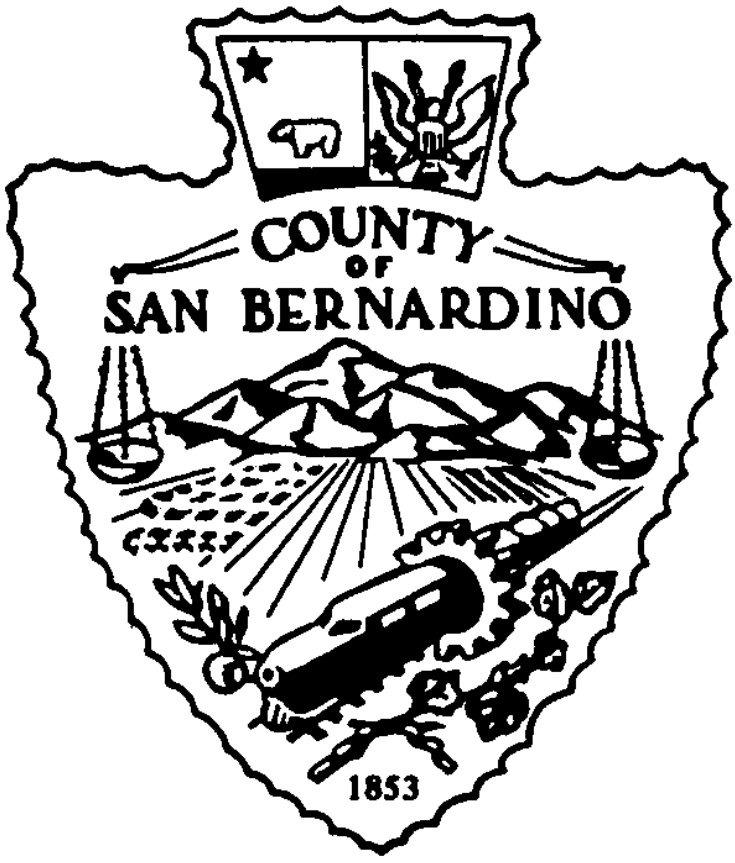
Reporting Procedures



County of San Bernardino
RISK MANAGEMENT DIVISION/HUMAN RESOURCES

REPORTING PROCEDURES

For

OCCUPATIONAL INJURIES AND ILLNESSES
MODIFIED DUTY
VEHICLE ACCIDENTS
PROPERTY DAMAGE
CLAIMS AGAINST THE COUNTY
PERSONAL PROPERTY CLAIMS
VIOLENCE IN THE WORKPLACE
BLOODBORNE PATHOGEN PROGRAM

September 2000

TABLE OF CONTENTS

Risk Management Division/Human Resources
REPORTING PROCEDURES

rmdclericalsupport/wp/stdrdprcman/reporting133.doc
safety/docs/sftymnl/reporting133.doc (4-03)

REPORT FORMS TO USE

1. **Earthquake/Fire/Glass Breakage/Vandalism/Malicious Mischief/Flood Damage, disappearance or theft of County Property, money or securities.**
   a. To a vehicle, use Incident Report Form (No. 15-13866-000 Rev. 1-94).
   b. To other County or District property, monies or securities. Always obtain police report for monies loss, vandalism or malicious mischief. Use Incident Report Form (No. 15-13866-000 Rev. 1-94) and indicate "Other Accident."

2. **Vehicle Incident.**
   a. With injury to County employee or volunteer, use three forms, Employee's Claim For Workers' Compensation Benefits (Form No. 07-633-000 Rev. 1/94), Employer's Report of Occupational Injury or Illness (Form No. 15-14248-000 Rev. 6/98), the Incident Report (Form No. 15-13866-000 Rev. 1/94), and Vehicle Accident Report (Form No. 15-5704-000 Rev. 1/94).
   b. Without injury to County employee or volunteer, use only the Incident Report (Form No. 15-13866-000 Rev. 1/94), and Vehicle Accident Report (Form 15-5705-000 1/94).

3. **Occupational Injury or Illness, Employee, Volunteer or Juror.**
   a. First Aid only, no doctor, clinic or hospital visit, or lost work time, use First Aid Record for notation.
   b. If doctor, clinic or hospital is visited, send a copy of the Medical Service Order (16-13212-000 Rev. 11/93) with the employee when he or she seeks treatment.
   c. If doctor, clinic or hospital is visited, or there is lost time from work, an Employee's Claim For Workers' Compensation Benefits (Form No. 07-633-000 Rev. 1/94) and Employer's Report of Occupational Injury or Illness (Form No. 15-14248-000 Rev. 6/98) must be completed.

4. **Non-County Personal Injury/Property Damage.**
   a. Non-employee, use Incident Report Form (No. 15-13866-000 Rev. 1/94).
   b. Non-County property damage, use Incident Report Form (No. 15-13866-000 Rev. 1/94).

5. **Claims Against the County.**
   a. If the incident or accident is unknown to you or your department and a party is requesting reimbursement for damages, the complainant should fill out Claims Against the County of San Bernardino Form (No. 07-8387-286). (Obtain copies of form from Risk Management, Liability Section, (909) 386-8631, or refer the party to Risk Management, 222 W. Hospitality Lane, 3rd Floor, San Bernardino Ca 92415-0016, to obtain a form.
   b. If you or your department are aware of the incident and an employee witnessed the incident, please contact Risk Management Division. Submit an Inter-Office Memo to Risk Management explaining the claim and if you feel the claim is valid or not.

6. **Personal Property Claim (Employee).**
   Loss or damage to employee's personal property is reimbursable if the loss was caused by peculiar circumstances, and not caused by the employee's own negligence. Eligible employees should submit the Personal Property Claim (Employee) Form (No. 07-13351-000 Rev. 2/94).

7. **Hazard Report.**
   To report a hazardous condition, piece of equipment or unsafe procedure, submit the Hazard Report Form (No. 15-18582-000).

8. **Violence in the Workplace Incident.**
   To report a violence in the workplace incident, use Workplace Threat Incident Against County of San Bernardino Employee (Form No. 10-299964) and County of San Bernardino Workplace Threat Mitigation Report (Form No. 15-199965-000).

9. **Bloodborne Pathogen Exposure Incident.**
   To report a Bloodborne pathogen exposure use Bloodborne Pathogen & Tuberculosis Exposure Report (Form No. 15-19418-000 Rev. 6/01).

10. **Hepatitis B Virus Immunization.**
    Use Hepatitis B Vaccine Authorization (Form No. 04-19404-000 ***or*** Hepatitis B Vaccine Declination (Form No. 04-19403-000).

NOTE: All forms are to be submitted to the Risk Management Division, 222 W. Hospitality Lane, 3rd Floor, San Bernardino CA 92415-0016. If your department or group has its own reporting procedures, these procedures are to be adhered to: however, all report forms must be submitted in a timely manner. If you have any questions call Risk Management at (909) 386-8655 for the Workers' Comp. Section, (909) 386-8631 for the Liability Claims Section and (909) 386-8623 for the Safety Section.

GENERAL REPORTING INFORMATION

All occupational injuries or illness necessitating medical treatment must be reported to Risk Management Division within 24 hours via fax. All other accidents or injuries must be reported to the Risk Management Division, within 48 hours on the appropriate form. **Serious vehicle accidents are to be reported by phone to Risk Management at (909) 386-8624. After hours, call Comm Center at (909) 356-3811.** Incomplete or unsigned forms will be returned to the originator. Claims for reimbursement for damage or loss of County property or monies and/or securities are to be reported immediately to Risk Management after calling the local law enforcement agency. A police report is required and all suspects are to be prosecuted.

If the injury to the County employee, juror or volunteer results in death, amputation of a limb, finger or toe up to the first joint, or severe injury to any part of the body, the injury must be reported Immediately by phone to the Risk Management Division, (909) 386-8655 or (909) 386-8624 or call Comm Center at (909) 356-3811. Risk Management will report to the Department of Industrial Relations, Division of Occupational Safety and Health as required by law.

If your group or department has developed its own reporting procedures, these are to be adhered to; however, all report forms included herein must be submitted in a timely manner to Risk Management.

Departments and Districts are responsible for keeping Risk Management advised of the status of employees, volunteers or jurors who are off work as a result of an occupational injury or illness. All off work orders are to be faxed to Risk Management at (909) 386-8711 or 386-8670. Original copies of off work orders or other pertinent paperwork should then be sent to Risk Management by Interoffice Mail or regular mail. Prompt notification eliminates overpayment of compensation benefits. If there is a recurrence of the injury or illness, the Risk Management Division is to be advised immediately so compensation may be resumed, if necessary. Also Risk Management personnel will need to determine whether this is actually a recurrence or a new injury which may require a new claim to be filed.

Outlined below are situations which require immediate notification of Risk Management:

1. Dangerous conditions that are an immediate hazard to employees or the public.
2. Fires.
3. Explosions.
4. Earthquakes.
5. Bomb threats.
6. Power outages.
7. Sewage spills.
8. Flooding.
9. Threats to or violence toward County employees.
10. Thefts of County property, money or securities.
11. Major accidents/fatal accidents.
12. Major injuries/illnesses, fatal injuries/ illnesses.
13. All Cal/OSHA inspections or contracts.
14. Building evacuations.
15. Outbreaks of illness with three or more employees (excluding flues and colds).
16. All employee driver license revocations/ suspensions.
17. All employee DUI's.

OCCUPATIONAL INJURY OR ILLNESS TO AN EMPLOYEE, JUROR OR VOLUNTEER

First Aid Only:

If an employee does not lose time from work, see a doctor, clinic or hospital, enter the name of the employee, the nature of injury, the cause of the injury and your signature (must be a supervisor's signature, or person left "in charge" during that time period) on the "First Aid Record" which is retained by your department (see instructions reverse side of "First Aid Record" form). This form should be kept with your First Aid Kit. It is used to document minor injuries incurred during employment that do not require medical treatment from a doctor, clinic or hospital. An employee is not required to seek medical treatment for an occupational injury or illness.

Medical Treatment Injury:

Forms needed: Employer's Report of Occupational Injury or Illness 5020 (Form No. 15-14248-000 Rev. 6/98);
Employee's claim for Workers' Compensation Benefits DWC-1 (Form No. 07-633-000, Rev. 1/94);
Medical Service Order (Form No. 16-13212-000, Rev. 11/93)

The employer is required to provide an **"Employee's Claim for Workers' Compensation Benefits"** (Form No. DWC-1) ***within 24 hours of notification to the department or district of an occupational injury or illness, or upon demand by the employee.*** Upon receipt of the completed form from the employee, the supervisor is to date and sign the form and immediately return a dated copy to the injured employee within 24 hours or a $5000 fine can be levied against your department. **A copy of this form is then faxed to Risk Management (or, for HSS employees, faxed to HSS Personnel) immediately or at least within 24 hours at (909) 386-8711**. The original and one dated copy are then mailed to Risk Management, (or, for HSS employees, mailed to HSS Personnel), Interoffice Mail. *Please refer to the instructions for completing this form on the following pages.*

The department designee should then complete the **"Medical Service Order For Occupational Injury or Illness"** (Form 16-13212-000, Rev. 11/93), keep a copy for their records, and give it to the employee to take with them to either a doctor or medical facility from the County Medical Referral List for Occupational Injuries, or if the employee has submitted a "Request to see Personal Physician" **prior to the injury**, and Risk Management has this form on file, they may be referred to this doctor. A copy of the Medical Service Order form should also be faxed to Risk Management immediately. The employee presents the original form to the doctor for completion, the doctor should then complete the bottom section, keep a copy for the chart record, and return the completed form to the employee. The employee is to return this form to their department supervisor, or other designee to advise the department of the employee's medical status. *Please refer to the instructions for completing this form on the following pages.*

The department designee **(not the injured employee),** shall complete four copies of the **"Employer's Report of Occupational Injury or Illness"** form. If additional space is needed to clarify information on this form, please attach this information on a separate sheet of paper. *Please refer to the instructions for completing the form on following pages.*

A copy of *each of these forms* should be faxed immediately to Risk Management at (909) 386-8711. Only one signature is necessary on the "Employer's Report of Occupational Injury or Illness in order for it to be faxed to Risk Management--again, this cannot be the injured employee's signature.

The originals and copies, as per the distribution indicated on each form, should be sent to Risk Management following the procedures your own group or department may have already in place for additional review and/or needed signatures. Copies of these forms should be retained by the department for their records.

County of San Bernardino

WHAT TO DO IN CASE OF ACCIDENT ON COUNTY PREMISES TO VISITING PUBLIC

This form is to be posted at each County work location on your bulletin board. Call 9-1-1 throughout San Bernardino County for immediate response from the proper Law Enforcement Agency.

Call Risk Management at (909) 386-8631 if you have any questions.

COUNTY OF SAN BERNARDINO

WHAT TO DO IN CASE OF
ACCIDENT ON COUNTY PREMISES TO VISITING PUBLIC

TO ALL EMPLOYEES:

1. Perform necessary first aid if you are trained to do so - such as stopping bleeding, restoring breathing, treating for shock and other First Aid necessary to maintain life and prevent further injury.

2. Advise the injured person to proceed as he would for an injury in his residence, calling his preferred doctor or hospital.

3. If the injured person has no preferred doctor or hospital, or cannot respond, and must be taken to a hospital or emergency clinic, proceed as follows:

   A. If the accident has occurred in a County building which is located within the city limits, call the local city police and request an ambulance. Give detailed instructions on how to reach your building and tell them where someone will be waiting to guide them to the injured person.

   Local City Police - Phone No. 9-1-1

   B. If the accident has occurred in a County building which is outside the city limits, call 9-1-1 and request an ambulance. Give detailed instructions on how to reach your building and tell them where someone will be waiting to guide them to the injured person.

4. If your building or facility has security guards, they should be alerted that an ambulance is on its way and informed where the injured person is located.

5. Send someone to wait for the ambulance at the designated location so the attendants can be guided quickly to the injured person. Do not leave the injured person until the ambulance arrives.

6. DO NOT MAKE ANY COMMENT CONCERNING THE INJURY OR COUNTY RESPONSIBILITY OR LIABILITY. Do not move an injured person unless it is required, then use reasonable care during movement. Wait for medical assistance.

7. File a report immediately with the County, using County of San Bernardino Other Incident report form available in your department.

Board of Supervisors
May, 1998

11-8086-000 Rev. 4/83

NOTICE TO EMPLOYEES

This notice must be posted by law at each County work location. It must be posted on your bulletin board with your Cal/OSHA Poster and appropriate summaries.

The bulletin board is to be readily accessible to all employees. All posted notices must remain visible at all times.

NOTICE TO EMPLOYEES

IF A WORK INJURY OCCURS...

California law provides certain benefits to employees who are injured or become ill because of the job.

WORKERS' COMPENSATION BENEFITS INCLUDE...

- MEDICAL CARE. All medical treatment required to cure the injury or illness - without cost to the employee. The employee should never see a bill, since all costs are paid directly by the employer or his agent.
- REHABILITATION. If the injury or illness prevents return to the employee's usual job, the employee may receive vocational rehabilitation. Again, all costs are paid by the employer.
- WORKER BENEFITS. Employees disabled by job-injury or job-illness receive income while unable to work. The payments are two-thirds of the employee's average weekly pay, up to a maximum set by State law. (Payments are not made for the first three days of disability unless the employee is hospitalized or unable to work more than 21 days.) Additional payments also will be made after the employee has reached maximum recovery if the injury or illness results in a permanent handicap. If the injury or illness results in death, benefits will be paid to the employee's surviving dependents.

IN THE EVENT OF A WORK INJURY...

Effective Jan 1, 1995, employees may use their personal physician if they have notified risk Management **in writing before the injury** and may change physicians 30 days after the injury.

1. Be sure first aid is given.
2. The employee's supervisor should take the injured employee to a doctor or hospital, if necessary.
3. Report every injury IMMEDIATELY to your supervisor. Any delay in reporting an accident may delay workers' compensation benefits.
4. If you have any questions about workers' compensation, please see your supervisor.

EMERGENCY TELEPHONE NUMBERS

SHERIFF/POLICE:	911	PARAMEDICS/AMBULANCE:	911
FIRE:	911	BOMB THREAT:	911

Your employer has received permission from the Director of the Department of Industrial Relations, State of California, to Self-Insure its workers' compensation liabilities under Certificate of Consent to Self-Insure No. P-0127, effective January 1, 1979. This Certificate is valid until revoked.

If you have any questions about your workers' compensation benefits, contact Risk Management Division, (909) 386-8655. If the answer is unsatisfactory, you may call the **Department of Industrial Relations Information and Assistance Center: Toll Free - at any time. The number is (800) 652-1500.**

Claims against this employer for workers' compensation benefits should be made by the employee to:

RISK MANAGEMENT DIVISION
222 W. Hospitality Lane, 3rd Floor, San Bernardino Ca 92415-0016
(909) 386-8655

FIRST AID RECORD

This form is required by Title 8, California Code of Regulations, General Industry Safety Orders. All injuries or illnesses which do not require medical treatment or lost time from work are logged on this form.

Full forms are to be filed with your OSHA 200 summaries by the supervisor.

The instructions for completion are on the reverse side of the form.

FIRST AID RECORD FORM

Explanation and Instructions in the purpose and use of the *FIRST AID FORM.*

Purpose:

1. To encourage reporting all work injuries, no matter how minor.
2. To insure that each injury receives adequate *FIRST AID* treatment.
3. To protect both the injured employee's and the County's interests under the provisions of Workers' Compensation law.
4. To enable the injured employee's immediate superior to review each case, to spot trouble conditions and further improve accident prevention measures.

Instructions:

To Supervisory Personnel: Bring this form to the attention of all your personnel. By the use of a clip board or other device, place this form in a conspicuous space readily available for the use of your personnel. Please be governed by purposes outlined above.

NOTE: If any minor injury later develops into a medical treatment case or lost time case (full day or more), a full report of the incident must be made on an Employee's Claim for Workers' Compensation Benefits and an "Employer's Report of Occupational Injury or Illness." Send a copy of the First Aid Record form that documented the original injury along with the Employer's Report of Occupational Injury or Illness.

To All Personnel:

Whenever you have a minor injury which does not require medical treatment, report the incident on this form and obtain FIRST AID promptly. Please be governed by the purposes outlined above.

Note: Additional copies of this form are available from Risk Management Division, Steve Robles, Safety Officer, (909) 386-8623 or can be copied in your office.

***Note: KEEP THIS RECORD WITH YOUR PERMANENT FILES**

FIRST AID RECORD

OFFICE: _____

Date of Injury	Name of Employee	Nature of Injury (Be Specific)	Cause of Injury	Supervisor Signature

E/FIRSTAID.DOC

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Form No. 07-633-000 Rev. 1/94

Not To Be Used To Report Exposure To Blood Or Exposure To Body Fluids Or Communicable Disease

May be used only if this exposure results in the employee contracting an illness or disease from such an exposure. Please refer to the instructions for completion of the "Bloodborne Pathogen & Tuberculosis Exposure Report" on page (176) of this manual.

✦✦✦

The "Employee's Claim for Workers' Compensation Benefits" form is required by State Law. The use of this form was required effective January 1, 1990. It is stocked at Central Stores.

THIS CLAIM FORM IS TO BE PROVIDED TO ANY EMPLOYEE WHO:

1) Requires medical treatment for an occupational injury or illness.
2) Makes a demand for a claim form.
3) Has an occupational injury or illness that you have knowledge of (knowledge can be from any source, including a supervisor or other person in authority).

All minor injuries, exposures, etc. that do not require medical treatment or result in lost time from work should be recorded on the "First Aid Record" form - please refer to the instructions for this form on page (142) of this manual. A worker's compensation claim does not need to be filed in this case *(You may provide the claim form to the employee, and if an employee still wishes to file a claim, they may do so.).*

The claim form must be provided by your department/district to the employee **within one working day** of your knowledge of an employee's injury or illness (You may also provide service by First Class Mail if the employee is unavailable). The employee is to be instructed to return the completed form to his/her supervisor or alternate as soon as possible.

A $5000 PENALTY CAN BE ASSESSED IF YOU FAIL TO PROVIDE THIS FORM TO AN EMPLOYEE WITHIN 24 HOURS OF YOUR DATE OF KNOWLEDGE OF THE INJURY/ILLNESS. THE PENALTY IS PAYABLE DIRECTLY TO THE STATE BY YOUR DEPARTMENT, NOT BY RISK MANAGEMENT.

➡THE TOP OF THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

The supervisor may assist the employee in completing their section of the form if the employee requests, or if the employee is unable to complete the claim form due to hospitalization or severe injury or illness. The form may also be completed by the employee's designated representative (this could be a family member, attorney, etc.). The employee should, however, sign their name on the claim if at all possible. If a claim form must be submitted without this signature, the supervisor, or department should advise Risk Management of the reason when submitting the claim. Since this is a legal document and is admissible in court, the employee's statement on this claim form and their signature attesting to the facts as recorded on the form are very important.

➡UPON RETURN OF THIS FORM BY THE EMPLOYEE OR THEIR LEGAL REPRESENTATIVE, THE DEPARTMENT/DISTRICT MUST FILL OUT THE BOTTOM SECTION OF THE FORM

The supervisor is to write in the date the claim form was received from the employee or his/her designated representative and sign as the "Employer Representative." A copy of the dated form must then be given back to the employee within one working day of receipt. If a dated copy is not provided to the employee, monetary penalties can be imposed by the State.

The supervisor or department designee should record their own statement regarding the circumstances of the injury/illness on the "Employer's Report of Occupational Injury or Illness." This form should be submitted to Risk Management at the same time as the claim form unless special circumstances preclude doing so. If special circumstances exist, please advise Risk Management prior to submitting the "Employers' Report." Instructions for completing the "Employer's Report of Occupational Injury or Illness" are included on page 153 of this manual).

For all Departments other than HSS (which is to FAX all paperwork to HSS Personnel), the "Employee's Claim for Workers' Compensation Benefits" must be FAXED to Risk Management within 48 hours to avoid additional penalties. Risk Management's FAX number's are (909) 386-8711 or 386-8670. After you have FAXED a copy of the "Employee's Claim for Workers' Compensation Benefits," the "Employer's Report of Occupational Injury or Illness," off work orders, and any other pertinent medical or other documentation to Risk Management, please process both forms and the original documentation through your department following your normal procedures. Any subsequent off work orders and medical documentation should also be FAXED immediately upon receipt.

If you have any questions, call the **Workers' Compensation Section of Risk Management at (909) 386-8655.**

DEPARTMENT OF INDUSTRIAL RELATIONS – DIVISION OF WORKERS' COMPENSATION

DEPARTMENT/DISTRICT: FAILURE TO PROVIDE THIS FORM TO AN INJURED/ILL EMPLOYEE WITHIN 24 HOURS OF RECEIPT OF REQUEST COULD RESULT IN SANCTIONS FROM THE STATE AGAINST THE COUNTY.

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

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

Complete for "Employee" section and give the form to your employer. Keep the last copy until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at **1-800-736-7401** if you need help in filling out this form or obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse 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.

EMPLOYEE:

1. Name _____ Today's Date _____

1A. Dept. regularly employed _____ 1B. Employee No. _____ 1C. Date of Birth _____

2. Home Address _____

2A. City _____ State _____ Zip _____

3. Social Security No. _____

3A. Home Telephone No. _____ Work Telephone No. _____

4. Date of Injury _____ Time of Injury _____ a.m. _____ p.m.

5. Address/Place where injury happened _____

5A. Occupation _____ 5B. Date of Hire _____ 5C. Supervisor's Name _____

6. Describe injury and part of body affected *(i.e., cut strain, fracture, rash, part of body affected, etc.)* _____

_____

6A. How did injury occur? _____

7. Signature of Employee _____

EMPLOYER:

(Department/District) COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.

8. Name and address of employer *(Group, Department and Division)* _____

_____

9. Date employer first knew of injury _____

9A. Knowledge of injury/illness acquired from *(employee, supervisor, relative, coworker, etc.)* _____

10. Date claim form was provided to employee _____

11. Date employer received claim form _____

12. Name and address of insurance carrier or adjusting agency RISK MANAGEMENT DIVISION, 222 West Hospitality Lane, Third Floor

San Bernardino CA 92415-0016

13. Signature of Employer Representative _____

14. Title _____ 15. Telephone _____

DEPARTMENT/DISTRICT: You are required to date this form and fax to Risk Management and provide a copy to employee, dependent or representative who filed claim within **one working day** of receipt of completed form from employee. If you fail to date stamp this form before returning to employee a $100 penalty could be assessed against your department/district.

DISTRIBUTION: **Original + 1 Dated Copy:** To Risk Management , 222 West Hospitality Lane, Third Floor, San Bernardino CA 92415-0016, Phone (909) 386-8655, Fax (909) 386-8711 along with completed Employer's Report of Occupational Injury or Illness within 48 hours of receipt of report from employee, dependent or representative. **Dated Copy:** To employee named in #1 above. **Dated Copy:** To Department/District named in #8 above.

07-633-000 Rev. 1/94 ***SIGNING THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM NOR IS IT AN ADMISSION OF LIABILITY.***

Forms/empl claim for wc benefits.doc

(THIS INFORMATION IS FOUND ON THE BACKSIDE OF THE EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS FORM)

WORKERS' COMPENSATION BENEFITS

MEDICAL CARE. Your employer will arrange for medical care, and all costs are paid directly by your employer's insurance company, so you should never see a bill. All medical treatment to cure or relieve your condition will be provided without a deductible or dollar limit.

PAYMENT FOR LOST WAGES. If you're temporarily disabled by a job injury or illness, you'll receive tax-free income until your doctor says you are able to return to work. Temporary disability payments are two-thirds of your average weekly pay, up to a maximum set by state law. (Some employees are entitled to receive full salary in lieu of temporary disability payments.) Payments are not made for the first three days you are disabled unless you are hospitalized as an inpatient or unable to work for more than 14 days.

REHABILITATION. If the injury or illness prevents you from returning to the same job, you may qualify for vocational rehabilitation benefits, with all costs paid by your employer's insurance company.

PAYMENT FOR PERMANENT DISABILITY. If the injury or illness results in a permanent handicap, permanent disability payments will be necessary after recovery.

DEATH BENEFITS. If the injury results in death, a benefit will be paid to surviving dependents.

If you need assistance completing this form or have questions regarding your benefits, please contact the State Office of Benefit Assistance and Enforcement by calling toll free **1-800-736-7401**. This service is provided to you at no cost. You also have the right to consult an attorney.

Forms/workers' comp benefits..doc

MEDICAL SERVICE ORDER

Form No. 16-13212-000 Rev. 11/93

If an employee is injured on the job or develops an occupational illness that needs medical care or treatment by a physician, clinic or hospital, a copy of the Medical Service Order is to be sent with the employee when the supervisor takes the employee to the doctor. This form is necessary to provide the correct billing address for the physician or medical facility and to ensure that all State-required reports are sent to the correct address. These forms are to be ordered from Central Stores.

After providing the needed medical treatment to the injured employee the doctor should complete the bottom section and give the original (white) copy and the second page (canary color) of the Medical Service Order back to the employee. The employee should then take the medical service order back to their supervisor as this has the injured employee's medical status on it. The supervisor retains a copy of the form and faxes, then mails the original, top copy to Risk Management *(The only exception to this procedure would be if it is a HSS employee who is injured, the department supervisor, or department designee should fax, and then mail all pertinent documents to HSS Personnel for handling and forwarding to Risk Management).*

There are instances when giving an employee a medical service order to obtain treatment may not be appropriate. Some examples of this are:

1. When an employee delays reporting an injury (This should be evaluated by Risk Management personnel to determine if a medical service order should be given).
2. When an employee has a "continuous trauma" type of injury such as hand, wrist, arm, neck, or back pain that develops over a period of time (weeks, months or years).
3. When an employee becomes ill on the job, but there is no particular part of their job or work environment that seemed to directly cause the illness on the day the employee claims the injury occurred.
4. Claims of Emotional Stress or Emotional Trauma unless there is a specific traumatic incident that happens on a particular day (legal disciplinary actions taken against an employee by an employer that may effect the employee's emotional state are not considered a work related injury).

If an employee claims one of these types of injuries/illnesses DO NOT SEND THEM TO A DOCTOR OR MEDICAL FACILITY WITH A MEDICAL SERVICE ORDER. You should still provide the employee or their representative with the "Employee's Claim for Workers' Compensation Benefits" and complete the "Employer's Report of Occupational Injury or Illness" as you normally would. You would then submit the forms and any related paperwork the employee provides to you to Risk Management (or HSS Administration if an HSS employee) via fax, and then the originals through your department channels as you would any other claim. Risk Management will review the claim and may need to advise the employee of a delay in provision of benefits until a decision can be made as to whether the condition is work related. State law allows a period of up to ninety (90) days, and sometimes more in order to collect all the facts surrounding the injury or illness. If you are not sure whether to give an employee a Medical Service Order, please call Risk Management at (909) 386-8655 for assistance. If it is "after hours", or on the weekend and the injury or illness falls in to one of the above categories, the employee should referred to their regular health care provider, using their private health insurance and retaining all receipts for payment related to the injury. Risk Management will then review the employee's claim and respond with a decision as to whether it will be an "accepted claim". If the claim is accepted, Risk Management can reimburse the employee if the documentation of costs can be verified.

HOW TO FILL OUT THE MEDICAL SERVICE ORDER

Form No. 16-13212-000 Rev. 11/93

1. Insert the **full name and address of the physician or medical facility chosen by the employee from the Physician's Referral List** on the first line of this form. If the employee has predesignated their own personal physician by submitting a request, in writing, to Risk Management prior to the injury, they may choose to use this physician instead. **Do not give an injured employee a medical service order that does not have the physician's or medical facility's name and address (at least the city) filled in. This is authorization for the doctor or facility to bill the County for their services.**

2. Insert the employee's full name, and middle initial, if any, on the second line.

3. Insert the date of the injury or illness and the exact time the accident occurred or the illness developed (if this information is known).

4. Insert the complete, official name of your department and group in the "Department (blank)." If you are working in a branch office, also include the location.

5. The signature of the supervisor or the department designee sending the employee to the doctor or medical facility here in "Signed By (blank)." **If the signature is not clearly legible, please print the name to side or under the signature so that the referring person can be identified.**

6. Insert the date the employee is being sent for medical care in the "Date (blank)."

7. The title (Job Classification) of the supervisor or department designee signing the Medical Service Order is inserted in the "Title (blank)."

NOTE: Definitions of physical activities are printed on back of form.

County of San Bernardino --- Risk Management Division

MEDICAL SERVICE ORDER FOR OCCUPATIONAL INJURIES OR ILLNESSES

DOCTOR _____ ADDRESS _____

_____ was injured on _____ at _____

Name of Employee **Date** **Time**

while in our employment. Please give the necessary medical care immediately, then complete and send the "Doctor's First Report of Occupational Injury or illness," all reports, bills, "Modified Work", "Off Work" and "Return to Work" orders to: **RISK MANAGEMENT DIVISION, 222 West Hospitality Lane, Third Floor, San Bernardino, CA 92415-0016 after faxing the completed Medical Service Order and Status Report to (909) 386-8711. Please call (909) 386-8655 if you have any questions.**

DEPARTMENT _____ Signed By _____

Name of Authorizer

Date _____ Time _____ Title _____

NOTE: The County of San Bernardino now has a mandatory Modified Duty Program for County employees injured on the job. Please return the original of this form with the employee to their department after faxing or mailing a copy to Risk Management.

PHYSICIAN'S AUTHORIZATION TO RETURN TO DUTY

Attached is the employee's physical job description, if possible.

EMPLOYEE _____ DEPARTMENT _____ INJURY DATE _____

This employee is under our care with a diagnosis of _____

1. ☐ May return to **REGULAR WORK** on _____ at _____
   Date *Time*
2. ☐ May return to **MODIFIED WORK** on _____ at _____
   with the following restrictions: *Date* *Time*

   ☐ No prolonged of repetitive:
   ☐ Bending ☐ Turning ☐ Stooping ☐ Kneeling ☐ Climbing
   ☐ Pulling ☐ Twisting ☐ Squatting ☐ Pushing ☐ Keyboard Use
   ☐ Standing ☐ Sitting ☐ Walking (excess of_____% of work shift _____ hours)
   (Specify length of time, if any, for limitations:_____ % of work shift_____ hours)
   ☐ Restricted from lifting in excess of _____ pounds
   ☐ No hazardous machinery operation
   ☐ Not permitted to operate motor vehicle (over_____hours daily)
   ☐ No exposure to noxious dusts, fumes, or chemicals
   ☐ No exposure to excessive noise
   ☐ No tasks requiring depth or color perception or point fusion
   ☐ No rotating or night shifts
   ☐ Restricted to working ____ hours per shift or 24-hour period.
3. ☐ **Restriction is temporary for _____ days _____ weeks _____ months**
4. ☐ **Other restrictions** _____

RETURN APPOINTMENT _____ at _____ . _____

Date *Time* *Physician's Signature*

DISTRIBUTION: Original – Risk Management Second Copy – Employee's Department Third Copy – Physician's Records Fourth Copy – Department's Temporary Receipt

16-13212-000 Rev. 11/93
rmdforms/medsvcordr.doc

DEFINITIONS OF PHYSICAL ACTIVITIES

1. SITTING: **Remaining in the normal seated position**. To rest weight on buttocks and back of thighs with legs bent at knees.

2. STANDING: **Remaining on one's feet in an upright position at a workstation without moving about**. To maintain entire body in erect posture without change in location.

3. WALKING: **Moving about on foot**. To move entire body for some distance using heel-toe gait.

4. LIFTING: **Raising or lowering an object from one level to another (includes upward pulling).** To exert physical strength necessary to move objects from one level to another.

5. CARRYING: **Transporting an object, usually holding it in the hands or arms, or on the shoulder**. While walking, to hold or rest weight directly on hands, arms, shoulders, back,

6. PUSHING: **Exerting force upon an object so that the object moves toward the force (includes slapping, striking, kicking, and treadle actions**). To exert force upon or against an object in order to move it away.

7. PULLING: **Exerting force upon an object so that the object moves toward the force (includes jerking).** To draw or haul toward oneself, in a particular direction, or into a particular position.

8. CLIMBING: **Ascending or descending ladders, stairs, scaffoldings, ramps, poles, and the like, using feet and legs and/or hands and arms. Body agility is emphasized. This factor is important if the amount and kind of climbing required exceeds that required for ordinary locomotion.** To ascend or descend ladders, scaffolding, stairs, poles, inclined surfaces.

9. BALANCING: **Maintaining body equilibrium to prevent falling when walking, standing, crouching or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats**. This factor is important if the amount and kind of balancing exceeds that needed for ordinary locomotion and maintenance of body equilibrium. To maintain body equilibrium on narrow or inclined surfaces.

10. KNEELING: **Bending legs at knees to come to rest on knee of knees**. To position body with one or both knees fully flexed and resting on level surface.

11. CROUCHING: **Bending body downward and forward by bending legs and spine**. To flex forward at waist with full flexion of knees.

12: CRAWLING: **Moving about on hands and knees or hands and feet**. To move entire body along a surface with hip and knee flexion and arm extension/flexion.

13. REACHING: **Extending hand(s) and arm(s) in any direction**. To position arms with full extension of elbows.

14. HANDLING/GRASPING: **Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand.**

15. MANUAL DEXTERITY: Makes skillful, coordinated movements of fingers and hands to feet, grasp, place, move or assemble objects.

16. BENDING: To flex upper trunk forward (knees extended, standing; knees flexed, sitting)

17. SQUATTING: To flex knees and hips, the buttocks being lowered to the level of the heels.

18. TWISTING: To rotate entire body to a change in direction.

19. TURNING: To rotate upper trunk to right or left from neutral while sitting or standing.

20. STOOPING: **Bending body downward and forward by bending spine at the waist. This factor is important if it occurs to a considerable degree and requires full use of the lower extremities and back muscles.** To flex upper trunk forward at waist and partial flexion of knees.

21. HEARING: Perceiving the nature of **sounds**.

NOTE: Descriptions highlighted in bold were excerpted from the "Dictionary of Occupational Titles, 4th Edition Supplement 1986".

medsvcrdef/rmdfrms/

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form No. 15-14248-000 Rev. 6/98 (State Form No. 5020)

<u>Not To Be Used To Report Exposure To Blood Or Exposure To Body Fluids Or Communicable Disease</u>

May be used only if this exposure results in the employee contracting an illness or disease from such and exposure. Please refer to the instructions for completion of the "Bloodborne Pathogen & Tuberculosis Exposure Report" on page (176) of this manual.

✦✦✦

The "Employer's Report of Occupational Injury or Illness" is always to be completed when an employee files a Workers' Compensation claim (it should not be completed just to document an incident. In this case, please refer to the instructions for the "First Aid Record" on page (142) of this manual.

☛**This form is to be completed by the employee's supervisor or other department designee**. **<u>It should never be completed by the injured employee.</u>**

<u>Please read all instructions in each section carefully so that the correct and most accurate information is recorded on the form.</u> This will help to expedite processing of the claim for your employee and assist Risk Management personnel in providing all benefits to which the employee may be entitled.

If you need to include any additional information that will not fit on the form, or other information to clarify that given on the form, please attach a separate sheet of paper to the Employer's Report.

For all Departments other than HSS (which is to FAX all paperwork to HSS Personnel), the "Employer's Report of Occupational Injury or Illness" should be FAXED to Risk Management immediately upon completion, or at least within 48 hours along with the "Employee's Claim for Workers' Compensation Benefits" form. Risk Management's FAX numbers are (909) 386-8711 or (909) 386-8670. After you have FAXED a copy of the "Employer's Report of Occupational Injury or Illness," the (Employee's Claim for Workers' Compensation Benefits" form, and any other pertinent documents (i.e., off work orders, return to work order, or other medical documentation from the treating physician), please process both forms and the original documentation through your department following your normal procedures. Any subsequent off work orders and medical documentation should be FAXED immediately upon receipt.

IF YOU HAVE ANY QUESTIONS ON COMPLETING THIS FORM, OR ANY OF THE PROCEDURES IN THE CLAIMS PROCESS, PLEASE CONTACT RISK MANAGEMENT AT (909) 386-8655

Step by step instructions are included on the following page to assist you in completing this form

HOW TO FILL OUT EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form No. 15-14248-000 Rev. 6/98 (State Form No. 5020)

1. Leave blank.*
1a. Complete (Use Section or Division's correct Organization Code. This five digit number can be obtained from your department payroll clerk).
2. Leave blank.*
2b Complete (Obtain this six digit coding from Fund & Accounting Manual or your department payroll clerk--may be alpha, or numerical, or both).
3. Do not complete.
3a. Complete (also known as "building number." This four digit number identifies the job site of the injured employee. *All County owned or leased buildings have their own designated code.* This information can be obtained from the County "Intranet" System. It is also published in the "Schedule of Buildings Owned by San Bernardino County or Rented/Leased by San Bernardino County."
4. Leave blank.*
5. Leave blank.*
6. Leave blank.*
7. Complete, full name of employee and employee number (if an employee has recently married, make sure to include maiden name in parentheses).
8. Complete.
9. Complete.
10. Complete (please list both the mailing and home address of the employee, if different, including zip code).
10a. Work phone number with area code.
11. X male or female.
12. Complete (employee's regular job title).
12a. Complete official department and district that employee works for (i.e., Sheriff/Patrol Division, Clerk of the Board of Supervisors, Public Health, General Services Group/Facilities Management, etc.).
13. Complete (date of hire with County--also, please indicate here or elsewhere on form if date of hire with this department is different than County hire date).
14. Complete (if employee is on other than a 5-day per week, Mon-Fri schedule, please indicate particulars of their schedule elsewhere on form or by attachment).
14a. X whether employee is permanent, part time, temporary or volunteer (this is very important because of different benefits).
14b. Do not complete.
15. Weekly wages (must be correct and up-to-date to ensure correct benefits).
16. Complete.
17. Complete.
18. Complete (exact time of day the incident occurred or the illness developed).
19. Complete.
20. Complete.
21. Complete.
21a. Complete.
22. Complete (if applicable).
23. Complete (if applicable).
24. Complete (if applicable).
25. Complete.
26. Complete.
27. Complete (date employer/supervisor was advised by employee or other source of employee's injury or illness).
28. Complete (date employee or their representative was given or mailed by "US Postal Service, First Class Mail" the employee claim form).
29. Complete as fully as possible.
30. Exact location of the injury, includes parking lots, grounds (street address, city).
30a. County where injured (and State if other than Calif.).
30b. Complete.
31. Complete.
32. Complete (if other employees injured, please indicate names elsewhere on form or by attachment).
33. Complete (with exact name of the machine, tool, object, chemical, etc. that the employee was using or came in contact with when injured. If a chemical or poison was involved and the exact name is not available, the trade name or any other information to identify it should be retained and reported here. The name of the Vendor is also desirable).
34. Complete with as much detail as possible.
35. Complete as fully as possible (save any tools, equipment, etc., for future inspection and investigation).
36. Complete (this is the name of the physician that first examines the employee for the injury or illness. If the employee sees other physicians, please include on a supplementary attached sheet. Include the name and address of doctor, hospital, or medical clinic where employee was treated for the injury or illness. If no medical treatment when form is completed, please indicate here).
37. Complete if the employee is hospitalized (be sure to include the name and address of the hospital here to ensure that the correct benefits are paid).
38. Complete if applicable (please include full names of witnesses and phone numbers, if available).
39. Complete.

*** Already filled out for you.**

SIGNATURE SECTION:

Completed by: Name of person completing the form **(cannot be the injured employee),** their Signature, Title and Date form completed.
Supervisor Signature * Department Head Signature * Assistant Administrative Officer Signature * Date signed by Supervisor

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	**PLEASE COMPLETE IN QUINTUPICATE (TYPE IF POSSIBLE)** This report is to be completed by the Supervisor, NOT the employee. Retain one copy for your files and mail the original and two copies to: COUNTY OF SAN BERNARDINO Risk Management Division/Human Resources 222 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0016	If there are any questions, please call (909) 386-8655 FAX UPON COMPLETION TO (909) 386-8711 or (909) 386-8670	OSHA Case NO. _____ ☐ Fatality

Any person who make or caused 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.

NOTICE: 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 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: **COUNTY OF SAN BERNARDINO ------ RISK MANAGEMENT**
1A. DEPT. ORG CODE
2. MAILING ADDRESS (Number and Street, City, ZIP): **222 WEST HOSPITALITY LANE, 3RD FLOOR, SAN BERNARDINO, CA 92415-0016**
2A. DEPT. FUND & SUB FUND
2. LOCATION, if different from mailing address (Number and Street, City, ZIP): **N/A**
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale, grocer, sawmill, hotel, etc.: **GOVERNMENT**
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.: **N/A**
6. TYPE OF EMPLOYER: ☐ PRIVATE ☐ STATE ☐ CITY ☒ COUNTY ☐ OTHER GOVERNMENT-SPECIFY

EMPLOYEE

7. EMPLOYEE NAME EMPLOYEE NUMBER
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER work
11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title ---- NO initials, abbreviations or numbers)
A. DEPARTMENT:
13. DATE OF HIRE
14. EMPLOYEE USUALLY WORKS: hrs per day ____ days per week ____ total weekly hrs ____
14A. STATUS (Check applicable status at time of injury) regular ☐ full-time ☐ part-time ☐ temporary ☐ volunteer
14B. Under what class code of your policy were wages assigned?
15. GROSS WAGES/SALARY $____ PER ____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES ☐ NO

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS
18. TIME INJURY /ILLNESS OCCURRED A.M. P.M.
19. TIME EMPLOYEE BEGAN WORK A.M. P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH MM/DD/YY
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
21A. MODIFIED DUTY PROVIDED? ☐ YES ☐ NO
22. DATE LAST WORKED MM/DD/YY
23. DATE RETURNED TO WORK MM/DD/YY
24. IF STILL OFF WORK CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS MM/DD/YY
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM MM/DD/YY
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, (If available, e.g.,. second degree burns on right arm, tendonitis of left elbow, lead poisoning.
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, E.G.,. welding seams of metal forms, loading boxed onto truck.
35. HOW INJURY/ILLNESS OCCURRED, DESCRIBE SEQUENCE OF EVENTS, SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJUTY/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.
36. NAME AND ADDRESS OF TREATING PHYSICIAN (Number and Street, City Zip)
36A. PHYSICIAN'S PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL, (Number and Street, City, ZIP)
38. WITNESS
39. CORRECTIVE ACTION TAKEN TO PREVENT RECURRENCE

DO NOT USE THIS COLUMN
Case No.
Ownership
Industry
Occupation
Sex
Age
Daily Hours
Days per week
Weekly Hours
Weekly Wages
County
Nature of Injury
Part of body
Source
Event
Soc. Source
Extent of Injury

Completed by (type or print)	Signature	Title	Date
Supervisor Signature	***Dept. Head Signature***	***Assistant Administrative Office Signature***	***Date***

FORM 5020 FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY 15-14248-000 Rev. 6/98

MODIFIED DUTY PROGRAM
(FOR EMPLOYEES WITH WORK RELATED INJURIES OR ILLNESSES)

The Modified Duty Program is a mandatory, County-wide program designed to return employees to the workplace doing tasks they are medically able to perform as soon as possible and until they are able to return to full duty. The County will accommodate an employee's medical restrictions so that injured workers will continue to earn regular salary and benefits for time worked. Employees unable to return to work in any capacity will be provided mandated benefits under California Workers' Compensation Law per the State Labor Code.

The County Modified Duty Coordinator (an employee of the Risk Management Division of Human Resources) assists the employee's department in coordinating the return to work of the employee with the assistance of the employee's treating doctor, the County Center for Employee Health & Wellness Doctor or Nurse, the Department's Modified Duty Coordinator, the injured employee's supervisor, and the injured employee.

When an employee's supervisor learns of a job-related injury or illness, they should refer to the "Reporting Procedures" section of this manual for specific requirements and forms which will need to be completed.

Once the employee has seen a doctor, they should either have the "Medical Service Order" which has been completed, or other paperwork from the doctor that gives information regarding the patient's medical status **(any medical status form or report that is signed by anyone other than a doctor is not valid--if it is signed by a physician's assistant or a nurse practitioner, it will not be accepted until the doctor's signature is obtained. If this delays the employee returning to work, the additional time off work may not be covered under workers' comp. benefits).** This form, or the doctor's paperwork should be taken back to the department by the employee and reviewed by the supervisor or other department designee.

If the employee does not return to his/her department with the medical documentation because he/she is unable to due to the injury, they should call the supervisor or other person "in charge" to advise them of this situation. Arrangements will then need to be made for the department or Risk Management to obtain the needed documentation. *It is the employee's responsibility to keep the department apprised of their medical condition initially, and thereafter with any changes in the status. The injured employee should contact their supervisor or other person designated by the department at least once a week. Failure to provide ongoing medical documentation could result in delay or denial of continuing benefits.*

The medical documentation should include one of the following statuses:

1. The employee is released by the treating doctor to return to work immediately, or to return to work the following day, or next shift, whichever is appropriate to the employee's work schedule.
2. The employee is taken off work by the doctor.
3. The employee is released to modified duties--there should be a clear indication of what the medical restrictions are to be.
4. If you are unsure of the status of a claim or anticipate potential problems with a claim, call Risk Management at (909) 386-8655 to speak to a Claims Adjuster, Claims Assistant or call the County Modified Duty Coordinator at (909) 388-4688.

➔ Do not implement modified duty assignments for employees with "stress related" or other emotional injuries/illnesses unless you are advised to do so by Risk Management personnel.

If the paperwork indicates that the status is either "off work" or "modified duty" the supervisor should then contact the department Modified Duty Coordinator to advise them of the employee's medical status. If the department Modified Duty Coordinator is unavailable, the supervisor should contact Risk Management to advise either the County Modified Duty Coordinator or the Claims Adjuster or Claims Assistant who will be handling the workers' comp. claim. A copy of the paperwork should be faxed to them at (909) 386-8711.

Employee's who are:

a) Taken off work due to an occupational injury and are being released back to work,
b) Are being sent back to work with medical restrictions by the treating doctor,
c) Are being released back to full duties after being on modified duties, or
d) Have a change in their medical restrictions by the treating doctor.

Must be seen at The Center For Employee Health & Wellness before returning to work.

The supervisor or other department designee makes the appointment for the employee. Occasionally, employees who are in very remote areas of the County may be released by the County Employee Health Doctor or Nurse by a phone interview--if this is the case, the supervisor should make these arrangements with the Center for Employee Health & Wellness Office, (909) 386-5150.

The employee will need to have been released to full or modified duty by the treating doctor, and obtain a written release from the doctor, before they are seen at the Center for Employee Health & Wellness for review of the doctor's return to work release. If possible, the employee should be scheduled for the Center for Employee Health & Wellness appointment at least one working day prior to the treating doctor's date of release so that the employee may return to work on the date specified by the treating doctor (weekends, holidays, and Employee Health & Wellness staffing needs may, in some instances, delay the date of the appointment, but this is usually not a problem).

The Supervisor, with assistance from the department Modified Duty Coordinator and if needed, the Department Human Resources Officer, will determine modified duty assignments for the employee when he/she returns to work. This return to work date must occur as soon as possible after the employee is released by the treating doctor. If there is no modified duty available within the employee's department, the County Modified Duty Coordinator will work with the Department Modified Duty Coordinator to place the employee in another County Department. It is important that all possibilities of placing the employee in their own department are explored as the employee's department continues paying the employee's regular salary and benefits for time worked.

Modified duty assignments will end upon release of the employee to full duty, or if modified duty assignments are no longer available, or if the employee's medical restrictions are determined to be of a permanent nature.

If an employee fails to show for scheduled assignments, interviews, or fails to follow the medical restrictions the doctor has imposed contact your Department Modified Duty Coordinator immediately. Workers' Compensation benefits will be terminated for employees who refuse to comply with modified duty assignments.

Also contact your department coordinator if the employee is missing scheduled doctor's appointments, physical therapy appointments, etc. If you are unsure what to do in a given situation, be sure to contact your Department Coordinator or Risk Management for guidance in handling the situation.

If your Department has other requirements or responsibilities regarding modified duty assignments for employee's, you should continue to adhere to the policy as set forth by your Department.

HOW TO FILL OUT
VEHICLE ACCIDENT REPORT FORM

Form No. 15-5705-000 Rev 1/94

1 **Before an accident happens**, fill in your department's telephone number and insert the Vehicle Accident Report Form in your vehicle's glove compartment. Motor Pool vehicles should have these already in the glove compartment. Check before leaving. Forms are available at Central Stores.

2. **When an accident has happened** to you, or you think you may be named as a party to an accident (even if the vehicle only touched you or swerved from your path and collided with others), park the car safely, immediately.

3. Take out the yellow Vehicle Accident Report and read Sections 1 through 6 carefully. Follow the instructions in these sections. Serious property damage is any damage over $2,500 to either party. Bodily injury can be as minor as a sore neck or arm.

4. The sections to be completed are mostly self-explanatory. It will help our investigator if you obtain the officer's name that took the initial accident report, and when possible, the accident report number (also known as a daily report (D.R.) or traffic accident (T.A.) number). Ask the traffic officer for the names of other parties if there are injuries. Complete <u>all</u> blanks.

5. Study the accident diagram and block out the types of intersections that don't apply to your accident. If this is not an intersection accident, draw curb lines over the intersection's cross streets and treat the diagram as if it showed a view of a straight street.

6. If serious injury occurs to a County employee or member of the public, call Risk Management Division at (909) 386-8631 as soon as possible. On weekends, call Comm Center at (909) 356-3811. They have the telephone number for our on-call staff. Follow any departmental directives you may have on serious injuries or accidents for further reporting.

7. This card is then given immediately to the employee's immediate supervisor so it can accompany the Incident Report form when sent to Risk Management Division/Human Resources.

THE INJURED PERSON

Names and Address	Age	Check Which (x)
1 _____		☐ Pedestrian ☐ Male ☐ Killed ☐ Driver ☐ Female ☐ Injured ☐ Passenger in Vehicle
2 _____		☐ Pedestrian ☐ Male ☐ Killed ☐ Driver ☐ Female ☐ Injured ☐ Passenger in Vehicle
3 _____		☐ Pedestrian ☐ Male ☐ Killed ☐ Driver ☐ Female ☐ Injured ☐ Passenger in Vehicle

Given First Aid by _____

Taken to _____ (Hospital, Clinic)

Did injured person make statement? _____

What? _____

_____

_____

_____

DAMAGE TO OTHER'S PROPERTY

Owner _____

Address _____ Phone: _____

Kind of property and how damaged _____

_____

_____

_____

Estimated cost of repairs $ _____

If vehicle: Make _____ Type _____ Yr. ____ License No. _____

Where may it be seen? _____

_____

Is it covered by insurance? ☐ Yes ☐ No Insurance Co. _____

Policy # _____

I declare, under penalty of perjury, the above is true and correct to the best of my knowledge.

_____ Date _____

Signature of County Driver

NOTE: If no police or traffic officer was able to respond to your request, report incident to local police department within 24 hours via a Counter Report.

County of San Bernardino

Vehicle Accident Report

INSTRUCTIONS TO DRIVERS

1. In case of accident, (no matter how slight), STOP at once and investigate. Write all facts of accident on this form.
2. Make no admission of liability and assume no responsibility for accident to anyone. The law requires that you need give only the following items of information.
   Name and address of driver.
   Name and address of owner of vehicle.
   License plate number of vehicle.
   If requested, exhibit your operator's or chauffer's license.
   (Calif. Vehicle Code, Section 20003)
3. If anyone is seriously injured, call a doctor and render reasonable assistance. Do not authorize medical or surgical relief except as is imperative at the time of the accident.
4. If accident is serious (results in bodily injury or serious property damages) call Traffic Emergency 911 and telephone your immediate superior or department.
   ALSO call Risk Management Division
   Phone: 386-8631
5. DO NOT ATTEMPT TO ADJUST THIS ACCIDENT.
6. ALWAYS call a Law Enforcement Officer to the scene.

Name of your Department/Group _____ Immediate Supervisor _____

Your Name _____ Work Phone # _____ Home Phone # _____

If you are not the County Driver, who was? _____

County Equipment Number _____ Vehicle License Number _____

Make _____ Model _____ Color _____ Yr _____

Name of Other Driver _____ Phone # _____ Address _____

License Number of Other Vehicle _____ Operator's License Number, Other Driver _____

Name and Address of Owner _____

_____

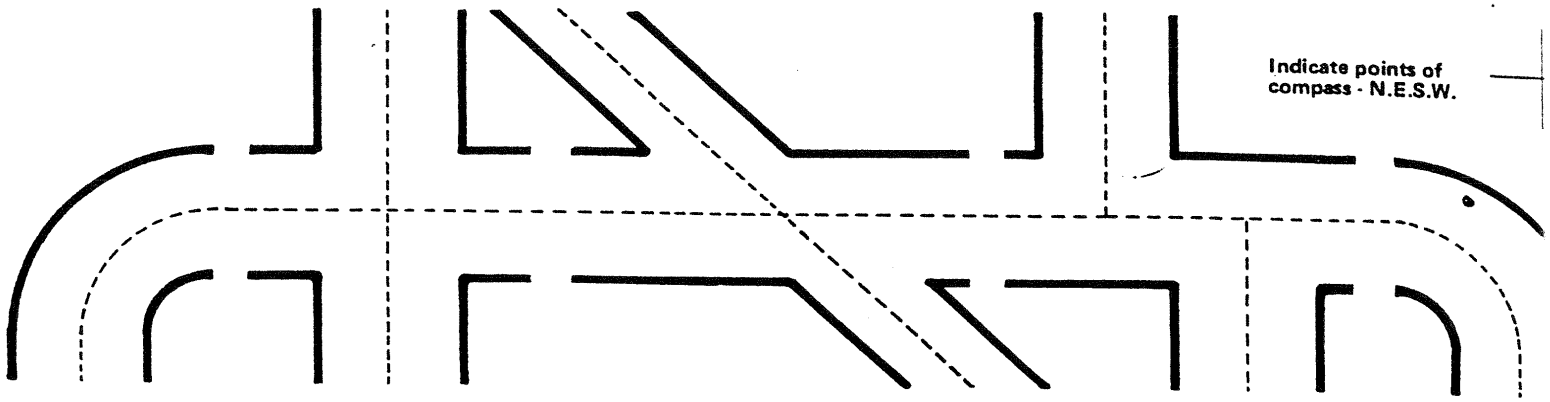
Name of Police Officer _____ ☐ Sheriff ☐ CHP ☐ City Police

Location _____

_____

NOTE: This form is for field use at the scene of the accident. Upon return to your office

Complete the following diagram showing direction and positions of automobiles or property involved, designating clearly point of contact.



INSTRUCTIONS: GIVE STREET NAMES, DIRECTIONS, AND LOCATIONS OF OBJECTS INVOLVED

(1) Number each vehicle and show direction of travel by arrow. → 1 2 ←

(2) Use solid line to show path of each vehicle before accident. → 1 dotted line after accident ·····→ 1

(3) Show motorcycle or bicycle by —→ O—O (4) Show pedestrian by —→ O (5) Show railroad by

IMPORTANT: COMPLETE NAMES AND ADDRESSES OF ALL WITNESSES. (6) Show County vehicle as number → 1

Other Witnesses or Persons Present	Address	Vehicle License No.	Phone
			☐ Home ☐ Business
			☐ Home ☐ Business
			☐ Home ☐ Business

NOTE: If unable to get names of witnesses, ALWAYS get the license number of those drivers that you believe witnessed the accident.

THE ACCIDENT

Date of accident: Month _____ Day _____ Hour _____ A.M. P.M.

Place of accident _____ *(Street Address)*

City, town or area _____

What direction were YOU going? _____ Other Vehicle _____

What side of street? _____ Other Vehicle _____

Speed of County vehicle _____ Other Vehicle _____

Weather conditions _____

Road conditions _____

No. of occupants of County vehicle — Adults: Male _____ Female _____ Minors: Male _____ Female _____

No. of occupants of other vehicle — Male _____ Female _____ Male _____ Female _____

Were YOU cited? _____ Charge _____

Was OTHER driver cited? _____ Charge _____

Describe accident fully: _____

☐ Seat belts installed. Seat belts used? ☐ Yes ☐ No

INCIDENT REPORT

Form No. 15-13866-000 Rev. 1/94

The instructions for completing are on the reverse side of the form.

This is a generic form used for all injuries and accidents involving members of the public, all vehicle accidents involving County/District vehicles, and all damage, theft, destruction or disappearance of County property, money or securities.

Police reports must be obtained for all money losses, vandalism or malicious mischief.

Instructions for Completion of
COUNTY OF SAN BERNARDINO INCIDENT REPORT
for County Vehicle Accidents and General Liability Property Damage

1. Full name of County driver or reporting employee
2. County employee's home address
3. County employee's home phone
4. County employee's department
5. County Department/District Department and Coding
6. Address of employee's department

6A. Complete

7. Complete
8. Complete
9. Complete
10. Indicate if you have had other accidents
11. Complete
12. Employee's driver's license number
13. Complete

(14-23. Complete only if incident involves a County vehicle)

14. Indicate 5 digit County vehicle number.
15. Give license plate number of vehicle
16. Complete
17. Complete
18. Complete
19. Complete
20. Complete
21. Complete
22. Acquire estimates of damage from Motor Pool
23. Complete
24. IMPORTANT! Give exact date of incident
25. Complete
26. Complete
27. Complete
28. Indicate location of enforcement agency taking report. NOTE: All accidents must be reported to Law Enforcement with jurisdiction.
29. Give exact location

29A. Nearest cross street to accident

30. Complete
31. Complete
32. Indicate full name of other party if applicable
33. Complete
34. Complete
35. Complete
36. If owner is other than No. 32, indicate full name
37. Complete
38. Complete
39. Describe property fully.
40. Is property insured?
41. Complete
42. Describe type of damage if any.
43. Give your opinion of cost to repair damage.
44. Complete
45. Full name, address and phone number of injured.
46. Complete
47. Complete
48. Check block to show if injured was in County vehicle, other vehicle or pedestrian
49. Full name, address and phone number of injured.
50. Complete
51. Complete
52. Check block to show if injured was in County vehicle, other vehicle or pedestrian.
53. Full name, address and phone number of witness
54. Check block to show if witness was in County vehicle, other vehicle or pedestrian.
55. Full name, address and phone number of witness
56. Check block to show if witness was in County vehicle, other vehicle or pedestrian.

NOTE: Report is **never** to be completed by employee involved in Automobile Accident. Form must be completed and signed before submitted.

incidntrpinstrc/rmdfrms
Human Resources/Risk Management 4/90

County of San Bernardino
INCIDENT REPORT

CONFIDENTIAL

(See page 2 for instruction) PLEASE TYPE

☐ **Auto** ☐ **Other Accident**

R.M.D.

COUNTY OF SAN BERNARDINO
222 West Hospitality Lane, Third Floor
San Bernardino, CA 92415-0016
(909) 386-8631

- Complete Items No. 1 through No. 56
- Acquire supervisor's comments and signature
- Acquire signatures of Department and Group Head
- Submit with yellow Accident Report card to Risk Management within 24 hour of incident

Disposition: First and Second copy to: Risk Management
Third copy to Dept.

SARB NO.:

COUNTY EMPLOYEE

1. Driver (or Reporting Employee for Non-Auto)	2. Home Address	2a. Social Security #	3. Home Phone
4. Department / 5. Dept. No. _____ Fund _____	6. Address of Department	6A. Contract city, if applicable	7. Dept. Phone
8. Date of Birth / 9. Date of Hire / 10. Prior Accidents ☐ Yes ☐ No	11. Employee's Job Title	12. Driver's License No.	13. Work Phone

COUNTY VEHICLE

14. County Vehicle No.	15. Plate No.	16. Motor Pool Car? ☐ Yes ☐ No	17. Color	18. Year	19. Make	20. Model
21. ☐ Minor ☐ Major _____ ☐ Total Damaged Parts		22. Repair Estimate from Motor Pool $ _____		23. Where can car be seen? When?		

SUPERVISOR'S DESCRIPTION OF INDIDENT

24. Date of Incident	25. Time A.M. P.M.	26. Weather	27. Condition of Road	28. Reported to ☐ CHP ☐ Police ☐ Sheriff NOTE: All vehicle accidents must be reported Which office?

29. Location of Loss (Street address, city, state)

29A. Nearest Cross Street

30.
County Vehicle: ☐ Parked ☐ Stopped in Traffic ☐ Moving
Est. Speed _____ MPH
Other vehicle: ☐ Parked ☐ Stopped in Traffic ☐ Moving
Est. Speed _____ MPH

31. Supervisor's Description of Incident:

OTHER PARTY

32. Other Party's Name	33. Address	37. Driver's License No.	35. Phone
36. Owner	37. Address		36. Phone

39. Describe Property (If car, make, year, plate no.)	40. Other party insured? ☐ Yes ☐ No	41. Insurance Company and Policy No.

42. Describe Damage	43. Repair Estimate $ _____	44. Where can property be seen?	County Vehicle	Other Vehicle	Pedestrian

INJURIES

45. Name Address Phone No	46. Age	47. Extent of Injury ☐ Minor ☐ Major ☐ Death	48.		
49. Name Address Phone No.	50. Age	51. Extent of Injury ☐ Minor ☐ Major ☐ Death	52.		

WITNESS

53. Name Address Phone No.	54.		
55. Name Address Phone No.	56.		

SUPERVISOR'S REVIEW

1. Do you feel County driver could have avoided this accident? ☐ Yes ☐ No

1. Why? _____

Hours employee worked prior to Incident? _____

3. Were there any known mechanical defects of County vehicle? ☐ Yes ☐ No
If yes, list: _____

3A. Was safety equipment used? ☐ Yes ☐ No
If yes, note deficiencies, if any

4. What habits should County drivers develop to avoid a similar accident?

_____

Supervisor's Name – Typed/Printed

Department Head's Name – Typed/Printed

Asst County Administrative Officer (if applicable)

Supervisor's Signature ***Phone***

Department Head's Signature

Information received from our employee on this form is confidential and is to be used only for accident analysis.

Liability Representative's Name ***Liability Representative's Signature*** ***Date received in RMD***

15-13866-000 Rev. 1/00
forms/incidntrpt.doc

CLAIMS AGAINST THE COUNTY

Form No. 07-8387-286

This form is to be used by members of the public who feel they have suffered general or punitive damages due to the County's negligence.

Employees are not to express opinions, either orally or in writing, to claimants or their agents as to liability, investigation findings or possible claim approval.

Permanent records are available upon request from the Risk Management Division, Human Resources.

If an injury or property damage is reported which cannot be verified by the employee, and the individual concerned expresses a desire to file a claim against the County of San Bernardino, he should be advised only that:

1. The County Board of Supervisors have sole authority to approve payment of claims against the County over $50,000. Risk Management Division has sole authority to approve payment of claims under $50,000.

2. Complete the **"Claim against the County of San Bernardino"** form in triplicate (Form No. 07-8387-286). Advise the claimant to complete all blanks and attach copies of all bills or other proof of expenditure.

3. Submit the claim to:

Risk Management Division, Human Resources
222 W. Hospitality Lane, 3rd Floor
San Bernardino CA 92415-0016

4. Forms are available at Central Stores, Purchasing.

CLAIMS AGAINST
COUNTY OF SAN BERNARDINO

Date _____

TO: Risk Management Division
County of San Bernardino, State of California
222 W. Hospitality Lane – 3rd Floor
San Bernardino, CA 92415-0016

Claim is hereby made against the treasury of the County of San Bernardino, State of California, as follows

Less than $10,000 - State the total amount claimed $ _____
More than $10,000 - Check one of the boxes:
Municipal Court Jurisdiction ($10,000-$25,000) ☐
Superior Court Jurisdiction ($25,001 and up) ☐

Claimant makes the following statements in support of the claim:

1. Name of claimant _____
First Middle Last (Area Code and Phone No.)

2. Address of claimant _____
Street City Zip

3. Notices concerning claim should be sent to:
_____
Name Address Zip (Area Code and Phone No.)

4. Circumstances giving rise to claim are as follows: _____
_____

5 Date, Time and Place (city, street, cross-street) damage occurred and nature thereof:
_____

6. Public property and/or public officers or employees causing injury, damage or loss:
_____

7. Name, address and telephone number of witnesses: _____
_____
_____

8. Basis of computation of claimed amount is as follows:
Medical expenses to date _____ Lost wages _____
Estimated future medical expenses _____ General damages _____
Other expenses _____ Property damage _____
Other damages _____

_____
Claimant or Representative

CLAIM FORM MUST BE FILLED OUT PROPERLY OR CLAIM WILL BE RETURNED WITHOUT FILING

07-8387-286 clmsagnstco/rmdfrms

PERSONAL PROPERTY CLAIM (EMPLOYEE)

Form No. 07-13351-000 Rev. 2/94

It is the policy of the Board of Supervisors, in accordance with Section 53240 of the Government Code, to extend coverage of the Liability Insurance Sub Fund to provide for the repair or replacement of employee's personal property necessarily worn or carried by the employee that is lost or damaged in the line of duty without fault or negligence of the employee.

Reimbursement for repair or replacement of personal property may be made when the loss or damage is caused by peculiar circumstances arising out of the course of employment.

No reimbursement may be made for ornamental or jewelry items except for depreciated, functional value of watches, eyeglass frames and the like.

Reimbursement for loss or damage of personal transportation vehicles is not covered under this policy but is provided under Mileage Reimbursement in the County Travel Code.

Claims for reimbursement shall be filed on the **"Personal Property Claim (Employee)"** Form No. 07-13351-000, Rev. 2/94, along with all necessary receipts for repair or replacement.

Forward all damaged items via interoffice mail to Risk Management to ensure processing of your claim.

INSTRUCTIONS TO CLAIMANT

Complete Sections 1, 2, and 3 of this form.

Section 1 - Claimant Information. This section is self - explanatory. The information is necessary for processing your claim.

Section 2 - Narrative Description of Incident and Damage. Explain the circumstances which caused the incident and damage to occur, including (1) the date, (2) the time of day, and (3) location of the incident. Attach documents which substantiate the claim such as receipts showing actual purchase price of the lost or damaged item, industrial accident reports, arrest reports, repair orders for equipment which malfunctioned, and formal or informal incident reports. If there were witnesses to the incident, list their names, titles and phone extensions in the spaces provided.

Section 3 - Employee Valuation and Claim. In all cases of loss, the following columns must be completed:

Date of Loss
Item
Repair or Replace (Is the article to be repaired or replaced?)
Place an "X" in the appropriate column.
Date of Purchase
Purchase Price (Original cost of article)
Repair or Replacement Cost
(Repair Cost - The cost to repair the article)
(Replacement Cost - the cost to replace the article with a new article of comparable quality)
Amount of Claim

If the claim is for an article of clothing, indicate the condition of the clothing at the time of loss by placing an "X" in the condition column which applies:

Excellent:	Having the appearance of an exceptionally well-cared-for article which belies its age.
Average:	Having an appearance expected of an article which has had reasonable use considering its age.
Poor:	Having the appearance of extensive use but not of abuse, evidence of repairs, the presence of well-worn areas and permanent discoloration provided that they do not destroy the usefulness of the article, are considered to be signs of poor condition.

NOTE: The condition column should only be completed when reimbursement is sought for articles of clothing.

If more than one article was lost or damaged, list them in the extra space provided or attach an extra sheet if necessary. Be sure to sign and date your claim. Keep the original copy for yourself and then submit the claim to your supervisor for review and processing.

PERSONAL PROPERTY CLAIM (Employee)

Note: Damaged items must accompany claim.
See page 2 side for instructions.

County of San Bernardino
RISK MANAGEMENT DIVISION
222 West Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0016
(909) 386-8631

1. CLAIMANT INFORMATION

NAME		DATE OF HIRE
OCCUPATIONAL GROUP	JOB CLASSIFICATIONS	EMPLOYEE NO.
DEPARTMENT	DIVISION	
LOCATION ADDRESS		WORK PHONE
HOME ADDRESS		HOME PHONE

2. NARRATIVE DESCRIPTION OF INCIDENT AND DAMAGE (Include name of responsible party, if applicable; i.e., dog owner, patient, combative suspect)

WITNESS(ES) TO INCIDENT	NAME OF WITNESS	ADDRESS	PHONE

3. EMPLOYEE VALUATION AND CLAIM

DATE OF LOSS	ITEM (Include Brand)	REPAIR	REPLACE	PURCHASE DATE OF DAMAGED ITEM	PURCHASE PRICE OF DAMAGED ITEM	REPAIR OR REPLACE COST	CONDITION			AMOUNT OF CLAIM
							Excellent	Average	Poor	
TOTAL AMOUNT OF CLAIM										

I certify, under penalty of perjury, that the above is a correct report of the personal property loss and/or damage sustained by me, through no fault of my own, while engaged in official business for the County of San Bernardino, that the above bill is true and just and that payment therefore has not been received.

Signature of Claimant *Date*

4. DEPARTMENT HEAD REVIEW

The circumstances surrounding this claim have been investigated to my satisfaction. I have reviewed policy 06-07 of the County Policy Manual and this claim, if approved, complies with policy.

Recommendation ☐ Approved ☐ Denied

Department Head Approval By: Date

5. RISK MANAGEMENT DIVISION

☐ Approve ☐ Deny
Payment Authorized $ _____

Comments _____

Supervising Liability Claims Representative Approval By: Date

---- AUDITOR'S USE ONLY----

Accounting Code			Amount
FUND	DEPT	ORG	

APPROVED:

LARRY WALKER, Auditor/Controller

By _____ **, Deputy**

07-13351-000 Rev. 2/94
rmdfrms/prnslpro.doc

DISTRIBUTION: Original- Employee
First Copy – Department
Second Copy – Risk Management Division, Human Resources

County of San Bernardino
Risk Management Division
HAZARD REPORT
Form No. 15-18582-000

The instructions for completion are on the reverse side of this form.

This form is the tool for employees, supervisors or managers to report safety hazards. imminent hazards which endanger County employees or the public should be immediately telephoned to Risk Management at (909) 386-8624.

After hours, call the Comm Center at (909) 356-3811 and ask them to contact appropriate Risk Management staff.

HOW TO COMPLETE HAZARD REPORT

Form No. 15-18582-000

The purpose of the Hazard Report (Form no. 15-18582-000) is threefold:

1. To provide all County employees a formal method to report unsafe facility/work conditions and job practices, either real or perceived.

2. To provide management a formal method to document corrective action taken on all reported unsafe conditions and/or practices, as well as a method to solicit aid or input from outside the department in correcting conditions and practices.

3. To notify appropriate individuals outside the reporting department that a condition or practice exists which requires assistance in resolving.

ROUTING

1. Originating department is to maintain canary copy. Its purpose is to diary the condition for department management control as well as to provide permanent documentation that reporting and correction of unsafe situations is occurring.

2. Originating department forwards pink copy to Facilities Management for information and/or action as is appropriate. Facilities Management forwards pink copy to Safety Section/Risk Management Division following correction.

3. Originating department forwards white copy to Safety Section/Risk Management Division. Safety Section will log condition, recommend and monitor correction, and de-log as condition is resolved.

Top Portion of Form - For Employee and Department Use

1.	REPORTING EMPLOYEE	Full name of individual completing report. Reporting employee may exclude name if anonymity is desired. However, experience has shown that anonymously reported practices and conditions are frequently difficult to identify and correct.
2.	DATE	This should reflect the date report is actually completed.
3.	DEPARTMENT	Name of department where hazard exists.
4.	LOCATION	Complete address of where condition exists.
5.	DESCRIPTION	Report must include a description of condition or practice in detail sufficient to identify the problem.
6.	CORRECTIVE ACTION	An appropriate member of department management should review the report prior to routing. If condition is corrected within the department, report should so indicate. If necessary corrective action is beyond the scope of departmental correction, report should be routed with departmental recommendations.
7.	DATE CORRECTIVE ACTION TAKEN	This should reflect date that any actual departmental corrective action was completed.
9.	PHONE NUMBER	This should include a telephone number of the individual whom Safety Section can call relative to the hazard.
10.	ANONYMITY	The purpose of the Hazard Report is to assure that unsafe conditions are corrected. It is for this reason that department management must be the initial step in form routing. Employees who perceive the need for anonymity are to direct the form to management in such a way as to protect their identity. Employees in such circumstances will need to xerox the report if a copy is desired.

Lower Portion of Form - For Facilities Management Use

1.	DATE	This should reflect date that report of corrective action is being prepared. The narrative of corrective action should include date of such correction.
2.	CORRECTIVE ACTION	This section should include a complete report of all action taken to correct condition.
3.	SIGNATURE	Signature of Facilities Management Supervisor responsible for corrective action.
4.	TITLE	Title of Supervisor signing report.

County of San Bernardino
RISK MANAGEMENT DIVISION

HAZARD REPORT

Reporting Employee (Optional)	Date
Department	
Location of Condition	
Description of Hazardous Condition or Unsafe Practice:	
Corrective Action Taken or Recommended:	

Date Corrective Action Taken	Signature	Phone Number

DO NOT WRITE BELOW – FOR FACILITIES MANAGEMENT USE ONLY

THE FOLLOWING CORRECTIVE ACTION HAS BEEN COMPLETED:	
Title	Signature

DISTRIBUTION: Original – Risk Management
First copy – Originator
Second copy – Facilities Management

15-18582-000
rmdfrms/hazards.doc

HOW TO COMPLETE
WORKPLACE THREAT INCIDENT AGAINST COUNTY OF SAN BERNARDINO EMPLOYEE

Form No. 10-19964-000

County of San Bernardino Board of Supervisors policy 09-08 requires that written documentation be prepared on all incidents of violence or assaultive behavior, either real or perceived, direct or indirect, verbal or physical, against County employees.

Form No. 10-19964-000 which is available from Central Stores, has been developed to document both threatening and assaultive incidents.

The information requirements of the form are self-explanatory:

Items 1 through 3	Identify the individual who has threatened or assaulted an employee.
Items 4 through 7	Describe the threat or assault.
Items 8 through 13	Identify the employee as well as provide other contact information.

The document is to be immediately prepared by the threatened or assaulted employee's immediate supervisor. It requires no signature, and departments must not establish internal procedures that will delay the prompt distribution of documentation to Human Resources and Risk Management Division, Safety/Loss Prevention Section, via Interoffice Mail.

The form presumes, and should follow, telephone reporting to appropriate levels of Department Management, and the Personnel Officer and/or Safety personnel depending upon the nature of the incident and need for consultation, guidance or assistance.

County of San Bernardino

WORKPLACE THREAT INCIDENT
AGAINST COUNTY OF SAN BERNARDINO EMPLOYEE

1. **Name of individual threatening County employee:** _____
2. **Perpetrator's relationship to County:** _____
3. **Physical description:** **Height** _____ **Weight** _____ **Hair** _____ **Eyes** _____
   Ethnicity _____ **SSAN** _____ **CDL** _____ **DOB** _____
   Address/Phone: _____
   Distinguishing Characteristics _____ *(Attach Photo if possible)*
4. **Location of threat** _____
5. **Date** _____ **Time** _____
6. **Circumstances of threat & who heard it** _____
7. **Exact words of threat** _____
8. **Threatened County Employee** _____ **Phone** _____
9. **Department** _____ **Phone** _____
10. **Supervisor** _____ **Phone** _____
11. **Work Address** _____
12. **Building Safety Coordinator** _____ **Phone** _____
13. **Employee's home telephone** _____ **Cell Phone** _____
14. **Additional comments** _____

10-19964-000

DISTRIBUTION: Risk Management Division/Safety Section
Human Resources Officer
Sheriff 's Office of Safety & Security
Department

Forms/workplace threat incident report form new

HOW TO COMPLETE
WORKPLACE THREAT MITIGATION REPORT
(Form No. 15-19965-000)

The California Labor Code and Title 8 California Code of Regulations, General Industry Safety Orders, require prompt mitigation of hazards to employee safety and health.

Form 15-19965-000, which is available from Central Stores, has been developed to document the mitigation or abatement of a hazard to employee health and safety resulting from threats of assaultive behavior against employees.

As with the previously reviewed Workplace Threat Incident Report, (page 171) this Mitigation Report presumes telephone reporting and the appropriate involvement of senior Department Management, the Personnel Officer and/or the Risk Management Division Safety/Loss Prevention Section.

The form is self explanatory, is the approved method of documenting key mitigation or abatement actions which must be considered, and **requires the Department Head signature**, and the signatures of the Personnel Officer and/or Safety personnel, depending upon the involvement of the latter two individuals.

COUNTY OF SAN BERNARDINO
WORKPLACE THREAT MITIGATION REPORT

Name of threatened employee _____

Department _____

Supervisor _____

Work address _____

Work telephone _____ Home telephone _____

ASSESSMENT BY:

Department Head Name _____ Telephone _____

Personnel Officer Name _____ Telephone _____

Risk Mgmt/Safety Name _____ Telephone _____

RECOMMENDED ACTION:

☐ Armed security at worksite Date initiated _____

☐ Surveillance of perpetrator Date initiated _____

☐ Area lighting Date initiated _____

☐ Accompaniment to and from car Date initiated _____

☐ Change in work hours Date initiated _____

☐ Change in parking location Date initiated _____

☐ Surveillance of employee Date initiated _____

☐ Change in work location Date initiated _____

☐ Injunction against perpetrator Date initiated _____

☐ Buddy system Date initiated _____

☐ Other _____

_____

_____

_____

DISTRIBUTION: Original – Risk Management Division/Safety Section
First copy – Human resources Personnel Officer
Second copy – Department

15-19965-000
rmdfrm/wrkplcthrt.doc

County of San Bernardino
BLOODBORNE PATHOGEN & TUBERCULOSIS EXPOSURE REPORT

(INSTRUCTIONS ON REVERSE SIDE)

1. **SECTION 1**			
2. Employee Name		3. Birth Date	4. S.S.N.
5. Home Address (no., street, apt. #)			6. Home Phone ( )
7. (city, state, zip)			8. Work Phone ( )
9. Hire Date	10. Job Classification		11. Employee #
12. Dept. Org. Code	13. Dept. Fund	14. Sub Fund	15. Location Code
16. Department Name (specify section)			
17. Dept. Mailing Address (number, street, city, zip, mail code)			

18. SECTION 2 BLOODBORNE PATHOGEN EXPOSURE SECTION

19. Route of exposure: ☐Body ☐Clothing ☐Article ☐Sharps

20. If SHARPS: Type and Brand of Sharp — Complete additional sharps information on reverse side

21. Performing tasks as trained? ☐Yes ☐No If no, corrective action taken:

22. PPE Used: ☐Gloves ☐Gown ☐Apron ☐Goggles ☐Eye Shield ☐Other (specify)

23. Exposure Transmission: ☐Skin w/break ☐Mouth ☐Left Eye ☐Right Eye ☐Puncture ☐Other (specify)

24. Exposed body part: ☐Left ☐Right

25. ☐Finger ☐Hand ☐Arm ☐Face/Head ☐Torso ☐Leg ☐Other (specify)

26. Substance Involved: ☐Blood ☐Semen ☐Vaginal Secretions ☐Cerebrospinal Fluid ☐Other (specify)

27. How Exposed:

28. Extent of Exposure (explain and quantify if possible):

29. Actions taken following exposure: ☐Washing ☐First Aid ☐Irrigation ☐Other (specify)

Is the source known? ☐No ☐Yes If yes, source name, date of birth:

Source Status (to be completed by treating facility or Risk Management ONLY)

31. ☐HCV+ ☐HCV- ☐HBV+ ☐HBV- ☐HIV+ ☐HIV- ☐Unknown

32. SECTION 3 TUBERCULOSIS EXPOSURE SECTION (AIRBORNE)

33. How exposed:

34. Length of time in contact with source:

35. Is the source known? ☐No ☐Yes If yes, source name, date of birth

Source Status (to be completed by treating facility or Risk Management ONLY)

36. ☐Unknown ☐Active TB ☐Rule out TB Physicians name & phone:

EVALUATION/FOLLOW-UP TREATMENT AUTHORIZATION

Please provide this patient with medical evaluation/follow-up as provided by San Bernardino County Procedure, a copy of which has been previously provided. Above you will find background information relative to the incident. All billings for services are to be sent to:
San Bernardino County Risk Management Division, 222 W. Hospitality Lane, Third Floor, San Bernardino, CA 92415-0016

Supervisor's Name (type or print)	Supervisor's Signature	Phone	Title	Date

DISTRIBUTION: Original – Treating Facility Second Copy - Risk Management

Instructions for completing the Bloodborne Pathogen & Tuberculosis Exposure Report

This report includes medically sensitive information and is to be prepared and handled in strict confidence. Only these two pages are to be prepared as follows:

1) The employee delivers the first page to the approved medical facility to which he or she has been referred for evaluation and follow-up.
2) The second page is to be sent in a sealed envelope marked. *"Medically Sensitive and Confidential Information to be opened by Addressee only"*, to Human Resources/Risk Management Division, Attn: County Safety Officer, mail code 0016.
3) Additional information and requirements are contained in the Employee Safety & Health Manual in accordance with the California Code of Regulations, Title 8, Section 5193. Questions regarding this form and other safety related matters should be directed to the County Safety Officer.

This report is not to be copied or duplicated, nor is the information contained herein to be maintained in any fashion other than described above without the expressed written permission from the County Safety Officer. The information contained in the report is not to be released in any manner or to any person, other than outlined above, without review and approval by County Counsel, San Bernardino County. If the exposed employee desires to maintain a copy of this report, such copy is to be provided by the treating medical professional. San Bernardino County employees are hereby advised that in maintaining a personal copy of this report, they assume personal liability (both civil and criminal) for any release of confidential information on the source individual that may result from maintaining such personal copy.

Instructions - Complete Section 1 (1-17) for all exposures.

1-11 Self explanatory.
12-15 This information can be obtained through your Human Resource Officer or Payroll Clerk.
16-17 Specify your department, section and mailing address with mail code.

Complete Section 2 (19-31) for Bloodborne Pathogen exposures

19. What was contaminated on the source that came in contact with the employee.
20. Sharps – if a sharp (needle, razorblade, knife, etc.) was involved during the exposure and was being used in a controlled environment (hospital, medical aid, clinic, etc.), then document the type, brand and model of the sharp (e.g. 18g needle/ABC Medical/"No stick" syringe) and complete the following information:

Additional Sharps Information

A. Did the device being used have engineered sharps injury protection? ☐ Yes, continue ☐ No, skip to question B
   1. Was the protective mechanism activated? ☐ Yes ☐ No
   2. Did the exposure incident occur: ☐ Before ☐ During ☐ After activation

B. Exposed Employee: If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury? Explain: _____

_____

C. Exposed Employee: Do you have an opinion that any other engineering administrative or work practice control could have prevented the injury? Explain. _____

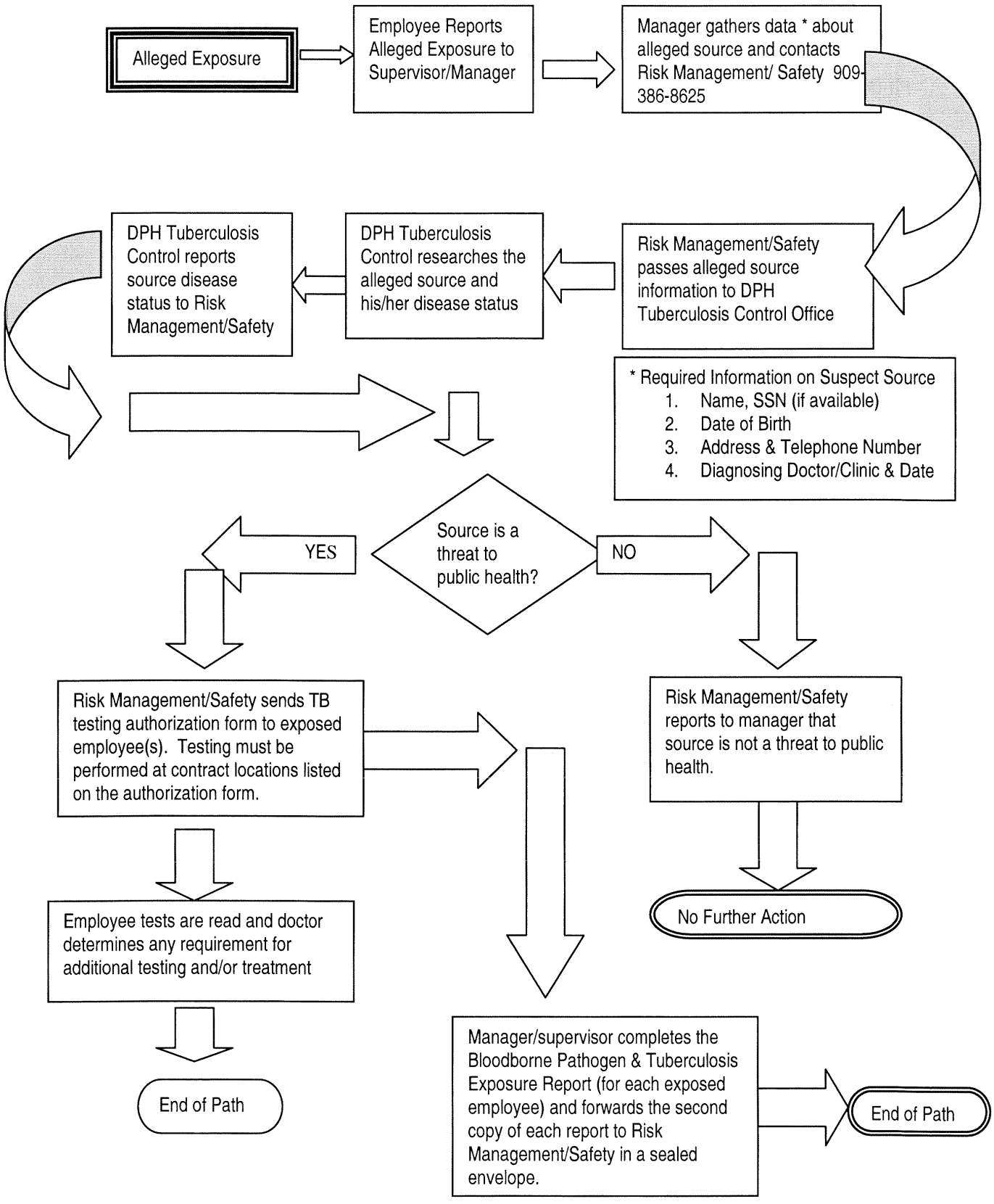
_____

21. Self explanatory.
22. Indicate what type of Personal Protective Equipment (PPE) was being worn while performing the procedure at the time the employee was exposed.
23. Indicate how the fluid or blood got into the employee's body. For example, blood in the eyes, puncture with a sharp, blood on skin that had a cut or scab, etc.
24-25. Indicate which part of the body was exposed.
26. Indicate what type of substance from the source individual came in contact with the employee's body part.
27. Exactly what was being done when the exposure occurred? For example, drawing blood, patting down a suspect, picking up a syringe with hands, etc.
28. Examples of Descriptive Terms: 2 drops or a quart of blood, a superficial or deep cut or puncture, etc.
29. Indicate what was done after the exposure to help the employee remove the substance involved.
30. Self-explanatory .
31. The treating facility or Risk Management will complete this section when applicable.

Complete Section 3 (33-36) For Tuberculosis exposures

33. Exactly what was being done when the exposure occurred? For example, transporting the source in a vehicle, entered the room to deliver a tray, etc.
34. Indicate the span of time the employee was in contact with the tuberculosis patient; e.g. 5 minutes, 5 hours, etc.
35. Self explanatory.
36. The treating facility or Risk Management will complete this section when applicable.

Tuberculosis Exposure
REPORTING & RESPONSE



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HOW TO COMPLETE
HEPATITIS B VACCINE AUTHORIZATION
Form No. 04-19404-000

With the concurrence of Risk Management Division/Safety Section, employees identified as working in classifications, or at job tasks, which have more than an ordinary possibility of bringing the employee into contact with human blood or specifically identified other body fluids, which are sources of Hepatitis B Virus, are to be offered immunization from the virus.

Once employees in job classifications have been so identified by departments and Risk Management Division/Safety Section, and employees have accepted the offer of immunization, individual supervisors are authorized to refer employees to ***selected medical facilities*** for administration of vaccine.

1. The first line of the form must be addressed to the medical facility selected.

2. The second line must include the employee's PRINTED name, job title and social security number.

3. Indicate that the billing detail is to be sent to:

   Risk Management Division
   Attention: Safety Section
   222 W. Hospitality Lane, 3rd Floor
   San Bernardino CA 92415-0016

4. Provide the identifying information requested at the bottom of the form.

5. Distribute as indicated.

6. Advise employee to take authorization and white copy of the Bloodborne Pathogen & Tuberculosis Exposure Report to the medical facility selected.

County of San Bernardino
CAO/HUMAN RESOURCES
RISK MANAGEMENT DIVISION/SAFETY SECTION

HEPATITIS B VACCINE AUTHORIZATION

To: _____ Address _____

SSN

_____ _____ _____

Name of Employee **Job Title**

has requested immunization against Hepatitis B.

In providing service, please track this patient to assure the full series is completed. If after the patient has been reminded, he or she fails to proceed with the series, please contact the individual below authorizing this immunization.

Upon completion of the immunization series, please provide documentation of completion to the billing address shown below with a copy to:

Human Resources/Risk Management Division
Attn: County Safety Officer
222 W. Hospitality Lane, Third Floor
San Bernardino, CA 92415-0016

Billing detail to provided to the County Officer (address above)
Billing detail to be provided to:

County of San Bernardino _____ Department _____ Attention

_____ Street Address _____ City State Zip

Signed By _____ Department _____

Title _____ Telephone _____

Date _____

04-19404-000 REV 12/02

DISTRIBUTION: Original – Employee
Second Copy – Department
Third Copy – Risk Mgmt Div/Safety Section

HOW TO COMPLETE
BLOODBORNE PATHOGEN PROGRAM
HEPATITIS B VACCINE DECLINATION

Form No. 04-19403-000

With the concurrence of Risk Management Division, Safety Section, employees identified as working in classifications or at job tasks which have more than an ordinary possibility of bringing the employee into contact with human blood or other specifically identified body fluids, which are sources of Hepatitis B, are to be offered immunization from the virus.

Title 8, California Code of Regulations, Section 5193, General Industry Safety Orders requires that employees who decline to accept the offer of immunization from Hepatitis B Virus must complete a Declination Statement.

The required information is self explanatory.

In contrast to the distribution instructions at the bottom of the form, which will be changed in the next revision, the original of the form is to be given to the employee, the second copy is to be retained by the department, and the third copy is to be sent to Risk Management Division/Safety Section.

County of San Bernardino
HUMAN RESOURCES
RISK MANAGEMENT DIVISION/SAFETY SECTION

BLOODBORNE PATHOGENS PROGRAM

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood, body fluids or other potentially infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood, body fluids or other potentially infectious material and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

NAME _____ SSN _____

DEPARTMENT _____

SIGNATURE _____ DATE _____

DISTRIBUTION: Original – Treating Facility
First copy – Department
Second copy – County of San Bernardino, Risk Management/Safety Section

04-10403
rmdfrms/blood.doc