CHAPTER 10

REPORTING PERSONAL INJURIES AND ILLNESSES

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CHAPTER 10

REPORTING PERSONAL INJURIES AND ILLNESSES

10.00 INTRODUCTION

This chapter explains the procedures required to complete and process specific forms used to report and document occupational injuries and illnesses, from those requiring first aid to those requiring emergency treatment at a medical facility.

See Chapter 9 - FIRST AID AND EMERGENCY MEDICAL TREATMENT, which describes procedures for requesting first aid, first aid teams, and emergency transportation to a medical facility.

This chapter **does not** cover reporting **serious occupational injuries, illnesses, or fatalities** that are subject to special California Occupational Safety and Health Administration (Cal-OSHA) requirements. See Chapter 19 - SPECIAL REPORTING OF SERIOUS INJURY, ILLNESS, OR FATALITY, which describes the departmental reporting protocol.

10.01 PURPOSE

The purpose of this informations is to provide an explanation of the forms used to document occupational injuries or illnesses. The process includes documenting non-emergency medical care and arranging for emergency medical care at a clinic or hospital.

10.02 POLICY STATEMENT

Supervisors are responsible to report and document occupational injuries and illnesses and to arrange for appropriate placement when an employee is medically able to return to work.

10.03 CALIFORNIA WORKERS' COMPENSATION PROGRAM

The California Workers' Compensation (WC) Program was established by the State Legislature to provide employees who incur an occupational injury or illness appropriate and reasonable medical care and indemnity payments (or their dependents in the event of an employee's work-related death) as necessary.

10.04 STATE COMPENSATION INSURANCE FUND

The State Compensation Insurance Fund (SCIF) is the State agency that acts as the Department's insurance adjusting agent in the administration of the WC Program. SCIF directs the WC claims process, medical contacts, medical payments, disability payments, and death benefits.

10.05 MEDICAL PROVIDER NETWORK

The Medical Provider Network (MPN) is a group of medical providers selected by SCIF to provide medical treatment for departmental employees who suffer an injury on the job. Medical providers that are included in the network can be found by going to the SCIF website (www.scif.com) and selecting the link to Medfinder MPN.

If an injury does occur at work, an employee shall receive a copy of the "Employees Guide to State Fund's MPN." This guide will provide detailed information regarding SCIF's MPN, how to select or change treating physicians in the MPN, and how to schedule a medical appointment.

10.06 PREAUTHORIZATION OF TREATING PHYSICIAN

Labor Code Section § 4600(d) allows employees to predesignate a personal physician. The predesignation must occur prior to a date of injury and must be in writing. The physician must be the employee's regular physician and he/she must agree to the predesignation. In addition, the physician must have previously treated the employee and possess the employees medical records. A medical group may be predesignated in certain situations. To predesignate a physician, an employee must fill out the Personal Physician Predesignation form (PM-0942) and return it to his/her supervisor prior to an industrial injury.

10.07 OVERVIEW OF CALTRANS WORKERS' COMPENSATION PROGRAM

The Caltrans WC Program is administered by the Division of Human Resources (DHR), Office of Health and Safety (H&S), and by District H&S Officers. The Headquarters Return to Work Coordinators (RTWC) or District H&S staff coordinate the claim with SCIF regarding medical contacts, medical payments, disability payments, and death benefits.

Work-Related or Occupational Injury or illness

It is the goal of the Department to return an injured or ill employee to work as soon as medically possible following recuperation from a work-related injury or illness.

If it is determined that an employee will not be able to return to his/her normal duties as a result of a work-related injury or illness, a WC Case Manager and/or District H&S staff will attempt to modify the employee's current position or place him/her in a position in which he/she can perform the essential functions.

Non Work-Related Injury or Illness

The Reasonable Accommodation Program can provide assistance to accommodate employees who have become disabled due to a non-work related injury or illness. An affected employee must file a request for Reasonable Accommodation with his/her supervisor. Further information on the Reasonable Accommodation program is located on the H&S website at: http://admin.dot.ca.gov/hr/HEALTHSAFETY/ra/ra.shtml

10.08 REPORT OF MINOR INCIDENT (PM-S-0066)

A minor injury or illness is broadly defined as: *an injury or illness that requires only first aid and would not require the attention of a doctor (or other medically trained person) or a visit to a medical clinic.*

First aid for minor cuts and bruises, splinter removal, or other minor treatment that would be limited to the items found in State-approved first aid kits are normally classified as minor injuries.

For minor occupational injuries or illnesses, that ***do not*** require professional medical attention, the "Green Slip" (Form 66) should be used to document the incident. This form is not to be used if the injured or ill employee is taken to a medical facility for treatment.

Upon receiving notification of a minor injury or illness, the supervisor shall do the following:

- Give a Form (PM-S-0066), Report of Minor Incident, to the injured or ill employee to complete. (If the employee is unable, the supervisor may fill out the form for the employee.)
- The supervisor must sign the form.

The supervisor's signature indicates that the supervisor is aware of the incident/accident as reported by the employee and is ***not*** an admission of liability.

Completing the Form PM-S-0066 ensures that the accident has been properly reported, documented, and the employee's benefits are protected.

The Form PM-S-0066 shall be sent to:

- The District H&S Office **for District employees**; and
- The WC Case Manager **for Headquarters employees.**

The District H&S Officers and WC Case Manager will file and retain copies of the Form PM-S-0066 for one (1) year.

Note: If the injury/accident is due to toxic chemical exposure and falls under the Cal-OSHA regulations, the record must be maintained for 30 years. Contact the H&S Office for more details.

A sample of Form PM-S-0066, REPORT OF MINOR INCIDENT, is included at the end of this chapter.

10.09 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (SCIF 3301)

Upon receiving information that an injury requiring medical treatment occurred, the supervisor shall:

- Give the employee a copy of the Form SCIF 3301 (located on DHR's H&S website) within 24 hours of becoming aware of an injury or illness;
- Within **one working** day of receipt of a completed Form 3301 from an employee, the supervisor shall complete his/her section of the form **and provide the employee a signed/dated copy;**
- The supervisor **shall immediately send copies** to either the District H&S Office or the Headquarters RTWC. The forms will be reviewed and the information processed in compliance with established procedures; and
- Provide the employee a copy of the Acknowledgement of Receipt of Form 3301 (PMS-0012). The employee is to sign the form and return it to the supervisor. The supervisor shall sign the form and send copies to either the District H&S Office, or the Headquarters RTWC.

Samples of Form SCIF 3301, EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS, and Form PMS-0012, ACKNOWLEDGEMENT OF RECEIPT are included at the end of this chapter.

A WC flow chart is included at the end of the chapter as a reference guide as to determine which form(s) must be submitted when an employee suffers an industrial injury.

10.10 MEDICAL TREATMENT AUTHORIZATION (PM-S-0037)

The Medical Treatment Authorization form is used when an injured or ill employee is taken to a clinic or hospital for treatment by a physician or other medical professional. This form represents a financial authorization from Caltrans and SCIF to provide medical treatment to the employee. and ensures that by the medical provider's services will be paid by the employer through SCIF.

The original authorization form is given to the physician. Copies of this form are then sent to the Headquarters RTWC or the District H&S Office.

When to use the MEDICAL TREATMENT AUTHORIZATION

Whenever an employee is injured, the supervisor shall do the following:

- Obtain a copy of the Form PM-S-0037 from the DHR H&S website at: http://admin.dot.ca.gov/hr/HEALTHSAFETY/Safety/safety_InjReportingReq.shtml
- Locate a medical provider within the SCIF MPN at http://www.scif.com if your facility has not previously identified a facility within the SCIF MPN.
- Arrange for the injured or ill employee to be transported to a SCIF MPN medical provider (unless the employee has a preauthorized treating physician) and give the form to the medical provider; and
- Discuss the injuries with the attending physician to determine the affected employee's ability to return to work/perform a full range of duties.

The form must indicate any limitations placed upon the injured or ill employee and outline any necessary follow-up treatment or appointments. The attending physician must sign the form before leaving the medical facility.

The form provides for the development of a **Modified Work Assignment Agreement** based on the physician's statement for the injured employee.

An example of the MEDICAL TREATMENT AUTHORIZATION, Form PM-S-0037, is included at the end of this chapter. The form may be modified to fit local needs.

10.11EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS (SCIF 3067)

Upon notification of an injury or illness, the first-line supervisor shall do the following:

- Fill out an EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS, Form SCIF 3067, located on the DHR's H&S website.

- Send the original form to:
  a.) the District H&S Office for **District employees**, or
  b.) the Headquarters RTWC for **Headquarters employees.**

The front of the form provides space for specific information regarding the injury or illness. The form's reverse side provides for the supervisor's and manager's review. **Both sides must be filled out completely by the supervisor.**

Section 2581.4 of the State Administrative Manual (SAM) requires:

- "**Someone Other Than and Superior to the Injured Person Should Fill Out the Form**."

- "The form shall **not** be completed by the injured employee, and **under no circumstances is the injured employee to sign the SCIF Form 3067."**

- "This form is State management's report of the incident to SCIF and is considered confidential."

The District H&S Officer or the Headquarters RTWC is responsible to send the completed Form 3067 to SCIF.

A sample of the SCIF Form 3067, EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS, is included at the end of this chapter.

10.12 ABSENCE AND ADDITIONAL TIME WORKED REPORT (STD. 634)

When an employee is absent due to an occupational injury or illness, Form STD 634 is used to record lost time, i.e., to report all absences for each pay period or portion thereof. The required medical documents to support the time off should be attached to the form and submitted ~~it~~ to the first line supervisor for approval.

Time off associated with an occupational injury or illness is charged to an employees leave credits.

Once the WC claim has been accepted by SCIF, the adjuster will verify an employee's time off as Industrial Disability Leave (IDL). DHR's WC Payroll Services Unit will restore the employee's used leave credits.

Time off associated with an occupational injury or illness ***must*** be reported on the Form STD 634 as outlined below:

- Electronic Time Reporting
  a.) Maintenance employees reporting time through IMMS, and
  b.) Staff employees reporting time through Staff Central

An STD 634 is used in addition to the electronic time reporting system. Indicate "Work-related Injury or Illness" in item 8 of the form and the date the injury or illness occurred. The employee's WC claim number should be recorded on the form. Circle all time due to the injury or illness on each individual date.

A sample of the Form STD 634 is included at the end of this chapter.

10.13 DATA INPUT FOR PERSONAL INJURY ACCIDENT (PM-S-0067)

The Safety Information Management System (SIMS) is a departmental program used to collect data on injuries and accidents. The DATA INPUT FORM PM-S-0067 is the last official document required in the sequence of events following the reporting of an occupational injury or illness.

The purpose of this form is to collect data that will identify the employee, the equipment, and detailed information describing the physical and environmental conditions surrounding the accident.

Supervisors are responsible to review the data fields and ensure that the information on the computer input document is complete and accurate. Upon completion, the form is to be sent to the District or Headquarters H&S Office. H&S staff review and verify the information and enters the data into SIMS.

A sample of the DATA INPUT FOR PERSONAL INJURY ACCIDENT, Form PM-S-0067, is included at the end of this chapter.

10.14 MODIFIED WORK ASSIGNMENT AGREEMENT (PM-S-0004)

This form is a formal written agreement between management and an injured or ill employee. The modified work assignment establishes a transition period that allows an employee to return to his/her position without loss of pay and benefits. It also used to documents the physical limitations established by the treating physician as the result of an occupational injury or illness. This form should be reviewed and/or renewed every 60 days based on medical reports.

Modified work is a temporary work assignment during the recuperation of an injured or ill employee that allows the employee the opportunity to return to work and perform short-term projects/assignments or limited tasks of usual and customary duties.

All modified work agreements must have written medical substantiation attached to the agreement document.

A MODIFIED WORK ASSIGNMENT AGREEMENT, Form PM-S-0004, lists the employee's name, job title, date of injury/illness, and effective dates of the modified work assignment.

Supervisors must ensure that the injured or ill employee has read, understands, and agrees to the provisions of the agreement before it is approved.

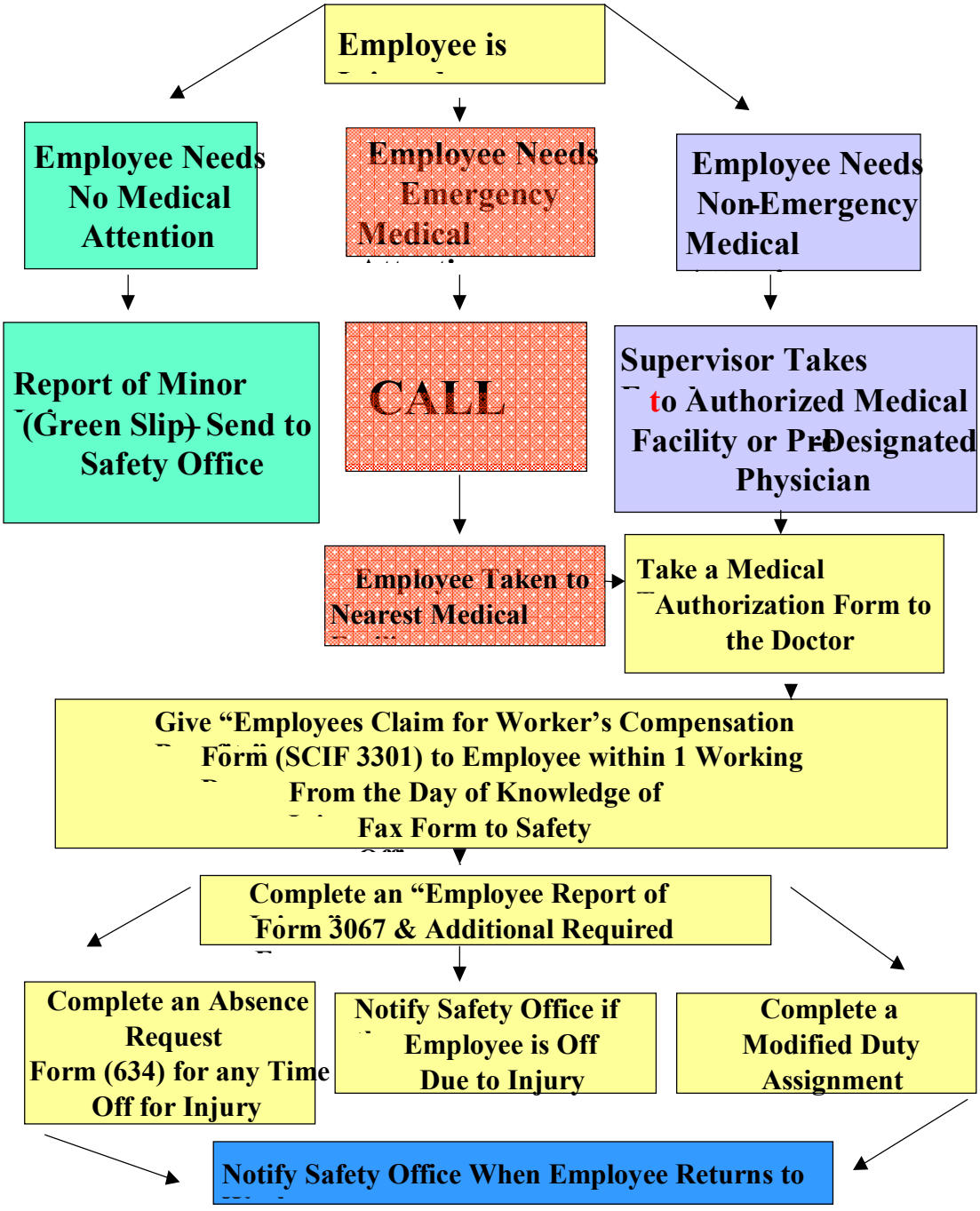
When to use a MODIFIED WORK ASSIGNMENT AGREEMENT

Supervisors shall make every effort to provide temporary modified work assignments for employees with occupational or non-occupational injuries or illnesses when their treating physician indicates:

- That the employee is **not able** to perform the **full range** of duties for a specific transition period of time.
- That the employee is **able** to perform a **limited range** of duties or other productive work during a specific transition period of time.

A sample MODIFIED WORK ASSIGNMENT AGREEMENT, Form PM-S-0004, is included at the end of this chapter.

10.16 APPENDIX



10.17

REPORT OF MINOR INCIDENT
PM-S-3068 (REV 9/07)

Front

District/Unit Number _____ Date _____

EMPLOYEE'S NAME (Print) _____

Job Title _____ Yrs. Of Exp. _____

Date of Incident _____ Time of Incident _____

Date Incident Reported _____

SUPERVISOR'S NAME (Print) _____

Job Title _____ Phone Number _____

Where Did Incident Occur _____

_____

Body Part Involved _____

Describe Incident and How It Occurred _____

_____

REPORT OF MINOR INCIDENT
PM-S-3068 (REV 9/07)

Back

Was Medical Treatment Offered? _____ Accepted/Declined?**

Was This Caused by a Hazardous Substance? _____ Yes _____ No

If Yes, What Substance? _____

Name of Witness(s) _____ _____

_____ _____

What Steps Have Been Taken to Prevent Similar Incident?

_____

_____

_____

Employee's Signature _____

Supervisor's Signature _____

** If medical treatment provided, Injury forms [3301/3047] must be completed.

MEDICAL TREATMENT AUTHORIZATION

Form PM-S-0037

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION

MEDICAL TREATMENT AUTHORIZATION

PM-S-0037 (REV 3/1997)

The supervisor will take the injured to the doctor for treatment.

ADJUSTING AGENT
STATE COMPENSATION INSURANCE FUND

CALTRANS USE ONLY
☐ First Aid ONLY, not reportable
☐ Injured Treatment report to Cal-OSHA

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798, et seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.24 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Officer.

* EMPLOYEE'S NAME	UNIT	COST CENTER	BUSINESS PHONE
* SUPERVISOR'S NAME			SINESS PHONE
* AUTHORIZED SIGNATURE			TE

TO ATTENDING PHYSIC

The form represents auth

The Department of Trans *time away from work may be kept to a minimum. Please consider the availability of this modified work before making a decision on our employee's estimated period of disability. Because of our varied work activities, usually some type of employment can be found to meet injured employee's medical limitations.*

If you have any questions regarding modified work assignments, please contact Caltrans District Safety Office or your Worker's Comp. Case Manager.

Please complete the items on the form below and return with employee.

INJURY STATUS REPORT

TREATMENT ADMINISTERED

- ☐ Office visit injury treatment
- ☐ Redress
- ☐ Medication
- ☐ Physical therapy
- ☐ Physical exam (results will be transmitted by other means)
- ☐ If presently working, return before or after shift on: ____ / ____ / ____

WORK STATUS

- ☐ Return to regular work Date: _____
- ☐ Return to modified work _____ days
- ☐ Unable to return to work for duration of disability _____ days
- ☐ On schedule established by initial report _____
- ☐ Re-evaluation or comments: _____

MODIFIED WORK AS INDICATED BELOW

- ___ 1. No prolonged standing or walking
- ___ 2. No climbing, bending, or stooping
- ___ 3. Limited use of the right/left hand
- ___ 4. Right/Left handed work only
- ___ 5. No work near moving machinery during modified work _____
- ___ 6. No twisting motion
- ___ 7. Weight lifting restriction:
  - ___ 0 - 15 pounds
  - ___ 15 - 35 pounds
  - ___ 35 - 50 pounds

DOCTOR'S COMMENTS

DOCTOR'S NAME	BUSINESS ADDRESS
DOCTOR'S SIGNATURE	BUSINESS PHONE

Complete original and 2 copies, distribute as follows:

- Original to District Safety Officer or WCCM
- Copy to physician
- Copy to supervisor or injured/ill employee

* *Fill in by supervisor*

NOTE: This form shall be given to the physician along with any explanation necessary.

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Form SCIF 3301

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

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

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

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

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

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

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

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

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

*Complete la sección **"Empleado"** y entregue la forma a su empleador. Quédese con la copia designada **"Recibo Temporal del Empleado"** hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401.** En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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

Employee: *Empleado:*

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

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

9. Name of employer. *Nombre del empleador.* _____
10. Address. Dirección. _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañia de seguros o agencia administradora de seguros.* **STATE COMPENSATION INSURANCE FUND** _____
15. Insurance Policy Number. *El número de la póliza del Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Date. *Fecha.* _____ 19. Telephone. *Telefono.* _____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (REV. 6-95) - DWC Form 1 (REV. 1-94)

STATE FUND COPY

THIS FORM IS NOT SHOWN FULL SIZE.

EMPLOYERS' REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form SCIF 3067

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail original and one copy to:

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 – 2581.5 for instructions on completion and routing.

BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case No.

☐ Fatality

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.

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 beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. DEPARTMENT | 1A. AGENCY CODE OR SCIF POLICY NUMBER | DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP) | 2A. PHONE NUMBER | Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP) | 3A. DIV./LOCATION CODE | Ownership
4. NATURE OF BUSINESS Governmental Agency | 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. | Industry
6. TYPE OF EMPLOYER | Occupation

☐ PRIVATE ☒ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME | CSID# | 8. SOCIAL SECURITY NUMBER | 9. DATE OF BIRTH (mm/dd/yy) | Sex
10. HOME ADDRESS (Number and Street, City, ZIP) | 10A. PHONE NUMBER | Age
11. SEX ☐ MALE ☐ FEMALE | 12. OCCUPATION (Regular job title–No initials, abbreviations or numbers) | CBID# | 13. DATE OF HIRE (mm/dd/yy) | Daily hours
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours | 14A. EMPLOYMENT STATUS (See instructions in 14A continued below.) ____ regular full-time ____ part-time ____ temporary ____ seasonal | 14B. Under what class code of your policy were wages assigned? | Days per week
15. GROSS WAGES/SALARY $ _____ per _____ | 16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO | Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy) | 18. MILITARY TIME INJURY/ILLNESS OCCURRED | 19. MILITARY TIME EMPLOYEE BEGAN WORK | 20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy) | Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ 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 ☐ | County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ 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) | Nature of injury
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. | Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) | 30A. COUNTY | 30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop. | 32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO | Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold. | Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck. | Extent of Injury
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP) | 36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP) | 37A. PHONE NUMBER
38. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO | 39. PERS/STRS MEMBERS ☐ YES ☐ NO | 40. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? ☐ YES ☐ NO
14A. EMPLOYMENT STATUS CONT. (Check current status of employment, not status at time of injury.)
____UNEMPLOYED ____ON STRIKE ____DISABLED ____RETIRED ____LAID OFF ____OTHER

Completed by (type or print)	Signature	Title	Date

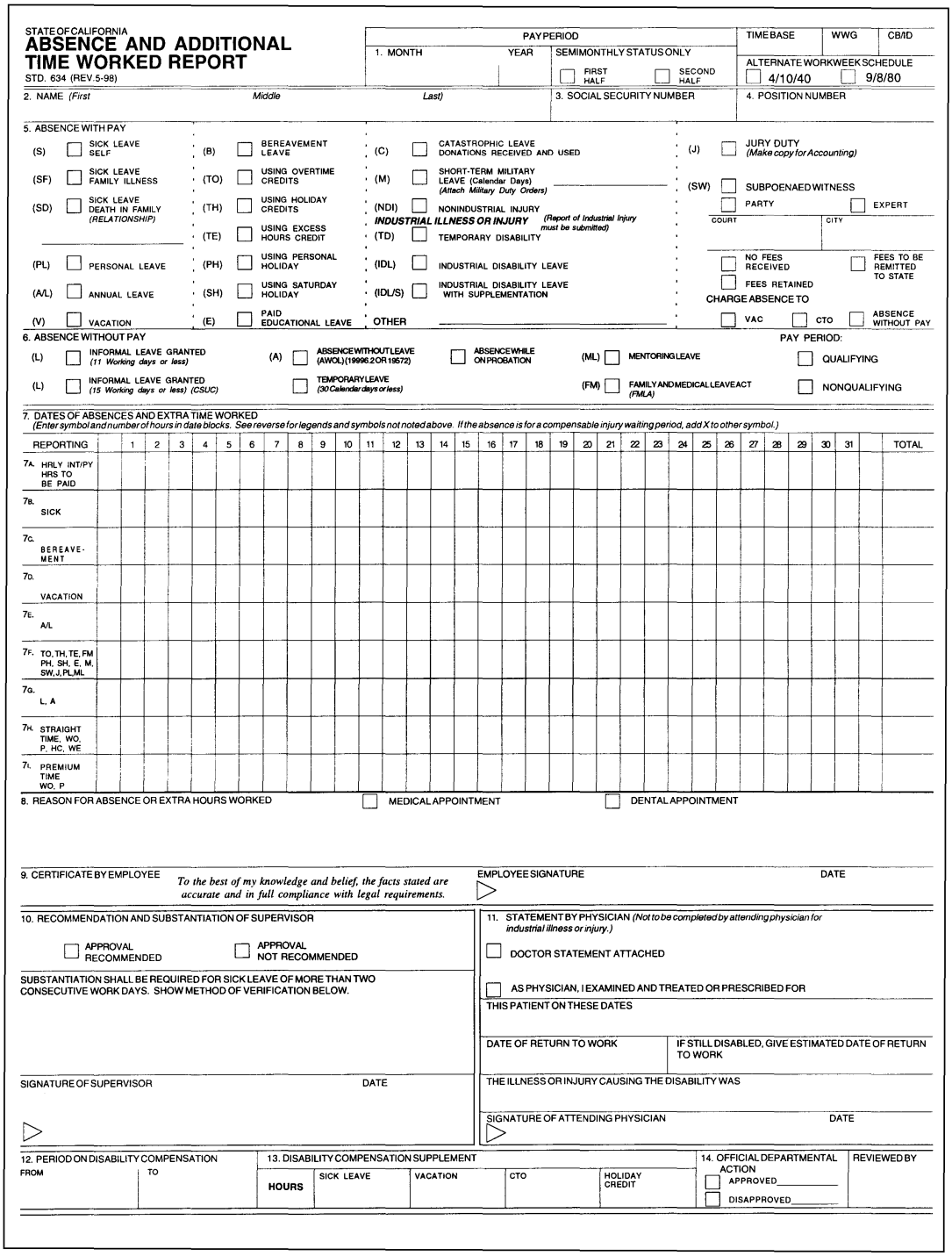
SCIF 3067 (REV. 2-93) STATE

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

THIS FORM IS NOT SHOWN FULL SIZE.

ABSENCE AND ADDITIONAL TIME WORKED REPORT

Form STD. 634



STATE OF CALIFORNIA
ABSENCE AND ADDITIONAL TIME WORKED REPORT
STD. 634 (REV. 5-98)

PAY PERIOD: 1. MONTH | YEAR | SEMIMONTHLY STATUS ONLY: ☐ FIRST HALF ☐ SECOND HALF
TIME BASE | WWG | CB/D
ALTERNATE WORKWEEK SCHEDULE: ☐ 4/10/40 ☐ 9/8/80

2. NAME (First Middle Last) | 3. SOCIAL SECURITY NUMBER | 4. POSITION NUMBER

5. ABSENCE WITH PAY

(S) ☐ SICK LEAVE SELF
(SF) ☐ SICK LEAVE FAMILY ILLNESS
(SD) ☐ SICK LEAVE DEATH IN FAMILY (RELATIONSHIP) _____
(PL) ☐ PERSONAL LEAVE
(A/L) ☐ ANNUAL LEAVE
(V) ☐ VACATION

(B) ☐ BEREAVEMENT LEAVE
(TO) ☐ USING OVERTIME CREDITS
(TH) ☐ USING HOLIDAY CREDITS
(TE) ☐ USING EXCESS HOURS CREDIT
(PH) ☐ USING PERSONAL HOLIDAY
(SH) ☐ USING SATURDAY HOLIDAY
(E) ☐ PAID EDUCATIONAL LEAVE

(C) ☐ CATASTROPHIC LEAVE DONATIONS RECEIVED AND USED
(M) ☐ SHORT-TERM MILITARY LEAVE (Calendar Days) _____ (Attach Military Duty Orders)
(NDI) ☐ NONINDUSTRIAL INJURY
INDUSTRIAL ILLNESS OR INJURY (Report of Industrial Injury must be submitted)
(TD) ☐ TEMPORARY DISABILITY
(IDL) ☐ INDUSTRIAL DISABILITY LEAVE
(IDL/S) ☐ INDUSTRIAL DISABILITY LEAVE WITH SUPPLEMENTATION
OTHER _____

(J) ☐ JURY DUTY (Make copy for Accounting)
(SW) ☐ SUBPOENAED WITNESS ☐ PARTY ☐ EXPERT
COURT | CITY
☐ NO FEES RECEIVED ☐ FEES TO BE REMITTED TO STATE
☐ FEES RETAINED
CHARGE ABSENCE TO: ☐ VAC ☐ CTO ☐ ABSENCE WITHOUT PAY

6. ABSENCE WITHOUT PAY
(L) ☐ INFORMAL LEAVE GRANTED (11 Working days or less)
(L) ☐ INFORMAL LEAVE GRANTED (15 Working days or less) (CSUC)
(A) ☐ ABSENCE WITHOUT LEAVE (AWOL) (19996.2 OR 19572)
☐ TEMPORARY LEAVE (30 Calendar days or less)
☐ ABSENCE WHILE ON PROBATION
(ML) ☐ MENTORING LEAVE
(FM) ☐ FAMILY AND MEDICAL LEAVE ACT (FMLA)
PAY PERIOD: ☐ QUALIFYING ☐ NONQUALIFYING

7. DATES OF ABSENCES AND EXTRA TIME WORKED
(Enter symbol and number of hours in date blocks. See reverse for legends and symbols not noted above. If the absence is for a compensable injury waiting period, add X to other symbol.)

REPORTING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
7A. HRLY INT/PY HRS TO BE PAID																																
7B. SICK																																
7C. BEREAVE-MENT																																
7D. VACATION																																
7E. A/L																																
7F. TO, TH, TE, FM PH, SH, E, M, SW, J, PL, ML																																
7G. L, A																																
7H. STRAIGHT TIME, WO, P, HC, WE																																
7I. PREMIUM TIME WO, P																																

8. REASON FOR ABSENCE OR EXTRA HOURS WORKED ☐ MEDICAL APPOINTMENT ☐ DENTAL APPOINTMENT

9. CERTIFICATE BY EMPLOYEE *To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.* EMPLOYEE SIGNATURE ▷ DATE

10. RECOMMENDATION AND SUBSTANTIATION OF SUPERVISOR
☐ APPROVAL RECOMMENDED ☐ APPROVAL NOT RECOMMENDED
SUBSTANTIATION SHALL BE REQUIRED FOR SICK LEAVE OF MORE THAN TWO CONSECUTIVE WORK DAYS. SHOW METHOD OF VERIFICATION BELOW.
SIGNATURE OF SUPERVISOR ▷ DATE

11. STATEMENT BY PHYSICIAN (Not to be completed by attending physician for industrial illness or injury.)
☐ DOCTOR STATEMENT ATTACHED
☐ AS PHYSICIAN, I EXAMINED AND TREATED OR PRESCRIBED FOR
THIS PATIENT ON THESE DATES
DATE OF RETURN TO WORK | IF STILL DISABLED, GIVE ESTIMATED DATE OF RETURN TO WORK
THE ILLNESS OR INJURY CAUSING THE DISABILITY WAS
SIGNATURE OF ATTENDING PHYSICIAN ▷ DATE

12. PERIOD ON DISABILITY COMPENSATION: FROM | TO

13. DISABILITY COMPENSATION SUPPLEMENT

HOURS	SICK LEAVE	VACATION	CTO	HOLIDAY CREDIT

14. OFFICIAL DEPARTMENTAL ACTION ☐ APPROVED ☐ DISAPPROVED
REVIEWED BY

THIS FORM IS NOT SHOWN FULL SIZE.

DATA INPUT FOR PERSONAL INJURY ACCIDENT

Form PM-S-0067

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION

DATA INPUT FOR PERSONAL INJURY ACCIDENT

PM-S-0067 (REV. 1/93)

Page 1 of 2 Front

CONFIDENTIAL

This document contains personal information and pursuant to Civil Code 1798.21 it shall be kept confidential in order to protect against unauthorized disclosure.

ACCIDENT INFORMATION (THIS FORM TO BE COMPLETED BY FIRST-LINE SUPERVISOR AND CHECKED BY THE SAFETY OFFICER)

DATE OF ACCIDENT	TIME (24 HOUR)	OTHER CALTRANS EMPLOYEE INJURED? ☐ YES ☐ NO CALTRANS VEHICLE(S) INVOLVED? ☐ YES ☐ NO	P -

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF HIRE

SOCIAL SECURITY NUMBER	BIRTH DATE	DRIVER'S LICENSE NUMBER	DRUG TEST (SENSITIVE POSITIONS ONLY) ☐ Yes ☐ No

CLASS-CODE	MAINTENANCE ACTIVITY NUMBER	EMPLOYMENT STATUS (CHECK ONE) ☐PFT ☐PI ☐LT ☐PPT ☐TAU ☐SPP ☐RA ☐SA ☐CE**

DISTRICT NUMBER	UNIT/COST CENTER*	LOST TIME (DAYS)	MODIFIED WORK (DAYS)	SCIF CLAIM NUMBER

DETAILED INFORMATION Circle the appropriate entry

A. TREATMENT STATUS
01 CAL-OSHA
02 FIRST AID
03 NOT CLEARLY JOB RELATED
04 EXPOSURE ONLY

B. FATAL IF YES, ENTER DATE OF DEATH
01 YES
02 NO _____

C. PERSONAL PROTECTIVE EQUIPMENT
01 YES
02 NO

D. PREVENTABILITY BY EMPLOYEE
01 YES
02 NO
03 INJURY CLEARLY THE FAULT OF ANOTHER CALTRANS EMPLOYEE
04 INJURY CLEARLY THE FAULT OF ANOTHER PARTY

IF 03 ENTER THE SSN OF THE CALTRANS EMPLOYEE:

___ __ ____

E. LOCATION OF ACCIDENT
01 CAFETERIA/RESTAURANT
02 CITY STREET
03 CONSTRUCTION SITE
04 CREW'S QUARTERS
05 ELEVATOR
06 EQUIPMENT BAY
07 FREEWAY/HIGHWAY
08 FREEWAY RAMP
09 FREEWAY LANE CLOSURE
10 HWY STRUCTURE/BRIDGE
11 LABORATORY
12 MAINTENANCE YARD
13 MOVING LANE CLOSURE
14 OFFICE BUILDING
15 PARKING LOT
16 REST AREA
17 RESIDENCE
18 SHOULDER CLOSURE
19 SHOP/WAREHOUSE
20 SIDEWALK
21 STAIRWAY
22 STREET/HWY LANE CLOSURE
23 TUNNEL/TUBE
24 COMMON CARRIER

F WEATHER/ENVIRONMENT
01 CLEAR
02 FOG
03 RAIN
04 SNOW
05 CLOUDY
06 WINDY
07 POOR LIGHTING
08 ADEQUATE LIGHTING
09 N/A

G. VISIBILITY
01 OVER 1/2 MILE
02 LESS THAN 1/2 MILE
03 LESS THAN 100 YARDS
04 N/A

H. ACTIVITY TYPE
01 BENDING
02 BURNING
03 CARRYING
04 CLIMBING
05 CRAWLING
20 RIDING
21 RUNNING
22 SHOVELING
23 SITTING
24 STANDING
25 STOOPING
26 USING BENCH TOOL
27 USING HAND TOOL
28 USING SHOP MACHINERY
29 WALKING
30 UNAUTHORIZED ACTIVITY
31 ASSIGNED DUTIES
32 ALTERCATION W/CO-WORKER
33 ALTERCATION W/SUPERVISOR
34 ADVERSE ACTION
35 USING PORTABLE POWER TOOL

I. ACCIDENT TYPE
01 ANIMAL/INSECT BITE/STING
02 CAUGHT IN MACHINERY
03 CAUGHT IN NON-MACHINERY
04 CHEMICAL EXPOSURE
05 CONTACT WITH ELECTRIC CURRENT
06 CONTACT WITH FIRE/FLAME
07 CONTACT WITH HOT OBJECT
08 CONTACT WITH POISONOUS PLANTS
09 CONTACT WITH SHARP OBJECT
10 EXPOSURE TO HIGH TEMPERATURE

I. ACCIDENT TYPE, CONTINUED
11 EXPOSURE TO LOW TEMPERATURE
12 EXPOSURE TO LOUD NOISE
13 EXPOSURE TO SUN
14 FALL FROM LADDER/STEPS
15 FALL FROM SPILLED LIQUID
16 FOREIGN OBJECT IN EYE
17 MOTOR VEHICLE COLLISION
18 RADIATION EXPOSURE
19 BODY MOTION/REPETITIVE
20 STRESS
21 STRUCK BY OBJECT

J. PART OF BODY, CONTINUED
32 SHOULDER
33 SPINE
34 THIGH
35 THROAT
36 TOE
37 WHOLE BODY
38 WRIST
39 MULTIPLE (SEE REVERSE)

K. NATURE OF INJURY
01 ABRASION
04 BACK/LOWER
05 BACK/UPPER
06 BUTTOCK
07 CALF
08 CHEST
09 CIRCULATORY SYSTEM
10 EAR/HEARING
11 ELBOW
12 PSYCHOLOGICAL
13 EYES/VISION
14 FACE
15 FINGER
16 FOOT
17 FOREARM
18 GENITALS
19 GROINS
20 HAND
21 HEAD
22 HEART
23 HIP
24 INTERNAL ORGAN
25 KNEE/LOWER LEG
26 MOUTH/TEETH
27 NECK
28 NERVOUS SYSTEM
29 NOSE
30 RESPIRATORY SYSTEM
31 RIB
16 BONE FRACTURE
17 HEARING LOSS
18 HERNIA
19 IRRITATION
20 NEUROLOGICAL
21 INFECTIOUS DISEASE
22 OVER EXERTION
23 SORENESS
24 PNEUMONIA
25 POISONING
26 SPRAIN
27 SPLINTER
28 STRAIN
29 TORN MUSCLE
30 STROKE
31 INHALATION
32 CUMUL. TRAUMA/PSYCHOLOGICAL
33 MULTIPLE (SEE REVERSE)
34 UNDETERMINED

S. OCCUPATION
01 ADM -ALL OFFICE WORK
02 LAB - LAB TESTING, FIELD AND LAB
03 SHP - MECHANICS, WELDERS, ETC.
04 CON -FIELD CONSTRUCTION
05 SUR - FIELD SURVEYS
06 FTR - FIELD TRAFFIC
07 TOL - TOLL SERVICES
08 FMT - FIELD MAINTENANCE
09 SPP - SPECIAL PROGRAM PEOPLE
10 CEM -CONTRACTORS EMPLOYEE**

☐ **CERTIFIED CORRECT; O.K. FOR DATA ENTRY**

_____
Safety Officer's signature

* ENTER THE UNIT NUMBER THE EMPLOYEE WAS CHARGED TO AT THE TIME OF THE ACCIDENT

** INCLUDED FOR TRACKING PURPOSES ONLY

FM 2238 M 95

MODIFIED WORK ASSIGNMENT AGREEMENT

Form PM-S-0004

STATE OF CALIFORNIA • DEPARTMENT OF TRANSPORTATION
MODIFIED WORK ASSIGNMENT AGREEMENT
PM-S-0004 (REV. 03/2000)

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☐ **WORK RELATED** INJURY/ILLNESS ☐ **NON-WORK RELATED** INJURY/ILLNESS

EMPLOYEE NAME		DATE OF INJURY/ILLNESS
SUPERVISOR NAME	BUSINESS PHONE	WORK UNIT/COST CENTER

NATURE OF INJURY OR ILLNESS

DESCRIPTION OF LIMITATIONS PREVEN

Sample

DESCRIPTION OF MODIFIED WORK ASSIGNMENT (DESCRIBE DUTIES TO BE PERFORMED)

NAME OF PHYSICIAN APPROVING RELEASE TO MODIFIED WORK

DATE MODIFIED WORK ASSIGNMENT TO BEGIN	DATE MODIFIED WORK ASSIGNMENT TO END

A MODIFIED WORK ASSIGNMENT IS **TEMPORARY** WORK INTENDED TO BE A TRANSITION PERIOD FOR RETURNING AN INJURED OR ILL EMPLOYEE TO HIS/HER POSITION WITHOUT LOSS OF PAY. **MAXIMUM DURATION OF A MODIFIED WORK ASSIGNMENT IS 90 CALENDAR DAYS**, UNLESS APPROVED FOR EXTENSION BY THE SUPERVISOR AND DISTRICT SAFETY OFFICER OR CASE MANAGER AS APPROPRIATE. EXTENSIONS MUST BE SUBSTANTIATED BY MEDICAL DOCUMENTATION. (ATTACH INFORMATION)

WE HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE DUTIES DESCRIBED IN THE MODIFIED WORK ASSIGNMENT AGREEMENT.

EMPLOYEE'S SIGNATURE	SUPERVISOR'S SIGNATURE
DATE OF SIGNATURE	DATE OF SIGNATURE

DISTRIBUTION - MAKE COPIES AND DISTRIBUTE TO:

FOR WORK RELATED:

1. ORIGINAL TO DISTRICT SAFETY OFFICE OR WORKER'S COMPENSATION CASE MANAGEMENT UNIT
2. ONE COPY TO SUPERVISOR
3. ONE COPY TO EMPLOYEE

FOR NON-WORK RELATED:

1. ORIGINAL TO SUPERVISOR
2. ONE COPY TO EMPLOYEE