WORKERS' COMPENSATION CLAIM PROGRAM
PROCEDURES FOR SUPERVISORS

If the employee's medical condition appears serious or life threatening, call 911. If the employee requires medical attention that is non-life threatening a medical authorization is to be provided immediately and the Workers' Compensation Claim Packet should be completed prior to treatment.

An Employee Claim Form for Workers Compensation Benefits or DWC-1 Form and Notice of Potential Eligibility must be provided within one (1) working day of knowledge of an injury.

The following handouts are to be provided to the employee:

A. How to File a Claim
B. Workers' Compensation Benefits Pamphlet
C. Medical Provider Network Notice (MPN)

The following forms are to be completed by the employee and Department:

A. Employee Claim Form for Workers Compensation Benefits (DWC-Form 1) and "Notice of Potential Eligibility")
B. Initial Lost Time Form
C. Authorization for Initial Medical Treatment
D. Receipt of Employee Claim Form & Notice of Potential Eligibility
E. Supervisors Report of Employee Injury/Illness
F. Form 5020 - Employer's Report of Occupational Injury or Illness
G. Prescription Form

After the claim packet is completed:

- Fax the **Authorization for Initial Medical Treatment Form** to the treatment facility of their choice. This **Medical Treatment Authorization** provides authorization to the Frontline provider clinic. The employee may only seek medical attention from one of these providers for the first visit unless he/she has previously properly designated in writing, his/her personal choice of physician to provide treatment in case of a work related injury. Contact your Workers' Compensation Representative or Human Resource Representative to verify whether the employee pre-designated a treating physician. If the employee designated his/her personal physician, the signed form should be submitted with the completed claim packet to Risk Management and the claim examiner. Complete the Medical Authorization and attach the Pre-designation so the employees' personal treating physician will have the County's billing information. If you are not able to give the form to the employee, fax the completed form to the Frontline Provider or Pre-Designated Provider.

- If the employee declines medical attention, ask the employee to fill out the **Authorization for Initial Medical Treatment Form** and sign the **Declination of Treatment.**

- Copy all completed forms and forward the originals to your Department Workers' Compensation Representative and e-mail a copy to RiskMail@Co.Tulare.CA.US .

The State of California requires that employers complete the form 5020 within 5 days of the date of injury. In addition, our claim administrator must adhere to strict time frames as required by the California Workers' Compensation Law. There may be penalties or fines for failure to comply with these requirements. Enter new claims into the on-line claim system within 3 days of the injury to ensure deadlines are met.

- **Promptly forward any doctor's notes and status reports with restrictions** to the Workers' Compensation Claim Representative or Human Resource Representative as they are received. Review the notes for work restrictions and determine if they can be accommodated. If you have any questions about accommodations, contact your Human Resource Representative for assistance or the County Leave Management Analysts.

- When the employee returns to work, the employee must provide you with a note from the doctor indicating **"release to return to work"** and/or **"release to regular duties"** or **"release to return to modified duty"** prior to the employee returning to work and performing his/her duties. If you do not receive a note but the employee states he/she has restrictions, call the Risk Management Technician handling Workers' Compensation for assistance.

Reinjury/Aggravation of Prior Injury

When an employee notifies you that he/she desires treatment, complete an **Authorization for Initial Medical Treatment** form for him/her. Notify the Workers' Compensation Claim Examiner with the date of prior injury within one (1) working day. The Workers' Compensation Claim Packet does not need to be completed again. Consult with Risk Management to determine if additional forms need to be filled out.

The following steps may be required:

Lost Time

If the employee will lose time consisting of more than one shift as a result of the injury, request the employee to complete the **Initial Lost Time Form.** **If the employee will be off work more than 40 hours have the employee and his/her physician complete the Medical Leave of Absence Request Form** before the leave commences or within five (5) working days after injury when serious injury occurs.

Forward completed forms to the Workers' Compensation Claim Representative within one (1) working day. If the employee needs assistance or information concerning the Workers' Compensation claim process or benefits, refer to CorVel Corporation and provide him/her with instructions on **How to File a Claim.** If you have any information you believe would be helpful to Risk Management as the claim is reviewed and managed, please contact the CorVel Corporation examiner or the Risk Management Technician at Risk Management.

Workers' Compensation Claim Program
How To File A Workers' Compensation Claim

1. **Report the injury to your Supervisor or Workers Compensation Representative.** You will be given an Employee Claim for Workers' Compensation Benefits and Notice of Potential Eligibility Form (DWC-1) and Workers' Compensation Benefits Pamphlet.

2. **Sign and date the Receipt of Claim Form (DWC-1)** and return it to the person who provided you the claim packet.

3. **Complete the Employee Section of the Claim for Workers' Compensation Benefits Form.** (DWC-1) remember to sign and date it. You may return the form to the person who gave you the claim packet. Keep a copy for your records. **Note**: Your claim has not been officially filed until you complete and return your claim form. Upon receipt of the completed claim form, you will be given an authorization for medical treatment and other necessary information.

4. **Complete the medical leave of absence form** and provide it to your doctor and to your Human Resource Representative if you have 40 hours lost time due to your injury.

5. **Read the Workers' Compensation Claim Form (DWC 1)** and the attached Notice of Potential Eligibility. The forms contain important information that will inform you about benefits you may be entitled to receive under the California Workers Compensation Statute.

6. **If your medical status changes, *it is your responsibility to notify your supervisor or Human Resources Department Representative immediately.*** Inform your Supervisor or Human Resource Representative if the doctor orders work restrictions, a period of temporary disability or you are returned to regular duty as additional paperwork may be required.

7. **Important:** California Workers' Compensation law requires the County to pay your medical costs from an on-the-job injury or illness. If you are disabled, the County may be required to pay a temporary disability benefit, which replaces a portion of your weekly salary. Furthermore, our claim administrators must adhere to rigid timelines in the issuance of benefits. <u>If you do not complete the claim form and return it to your WC Representative or Supervisor, these deadlines may not be enforceable.</u> You have not officially filed a Workers' Compensation claim unless you return the completed claim form to the County within 30 days of the date of the accident per Labor Code 5400.

8. To obtain more information about Workers' Compensation you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (559) 445-5355. For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: <u>http://www.dir.ca.gov/DWC/dwc_home_page.htm</u>

9. <u>**If you have any questions about How to File Your Claim for Workers' Compensation Benefits**</u> Please call the Risk Management Division at 623-0280. If you have questions about an existing claim, call CorVel Corporation at (916) 605-3800 (main) or (866) 849-4344 (toll free).

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

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

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

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

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde 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 see note below. ***Empleador—complete esta sección y note la notación abajo.***

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 compañía de seguros o agencia adminstradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

6/10 Rev.

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

INITIAL LOST TIME FORM

TO: **COUNTY RISK MANAGEMENT** **DATE:** _____

FROM: _____ **DEPT:** _____

This memo is to advise you that the following employee was injured on-the-job, therefore I am providing you with the required information in addition to Form 5020, -"Employer's Report of Occupational Injury or Illness", DWC Form 1 – "Employee's claim for Workers' Compensation Benefits", "Medical Service Order" and "Supervisor's Report of Employee Injury".

Name of Injured Employee: _ _____

Date and Time of Injury: _____

Date Last Worked: _____

Employee leave credits as of date of injury:

Total Sick Leave Available: _____
Total Vacation Leave Available: _____
Total CTO Leave Available: _____

SUPERVISOR'S SIGNATURE/DATE: _____

While you are on a workers' compensation leave of absence:

The County will integrate accumulated sick, vacation, or compensatory time off hours while you are receiving temporary disability benefits. Sick vacation or compensatory time off hours will be charged only for the portion of salary difference between the workers' compensation temporary disability benefit amount and your full salary. The County's third party claims administrator works directly with payroll to verify the hours available. The County will issue your check on the normal bi-weekly pay date. Once sick, vacation, or compensatory time off hours are exhausted temporary disability benefits will be issued directly from the third party claims administrator.

Law Enforcement and Safety personnel will receive a maximum of 52 weeks of 4850 pay. After 4850 pay is exhausted County will integrate accumulated sick, vacation, or compensatory time off hours while you are receiving temporary disability benefits. Sick vacation or compensatory time off hours will be charged only for the portion of salary difference between the workers' compensation temporary disability benefit amount and your full salary. The County's third party claims administrator works directly with payroll to verify the hours available. The County will issue your check on the normal bi-weekly pay date. Once sick, vacation, or compensatory time off hours are exhausted temporary disability benefits will be issued directly from the third party claims administrator.

EMPLOYEE'S SIGNATURE/DATE: _____

COUNTY OF TULARE

Risk Management Division

3530 West Mineral King Suite E
Visalia, California 93291
559-623-0280

AUTHORIZATION FOR INITIAL MEDICAL TREATMENT

Date: _____

Injured Employee: _____ Date of Injury: _____

Employee Address: Home _____ Phone #: _____

Employee reports an injury to (body part) _____

How did Injury Occur: _____

HR or WC Representative Completing Authorization: _____

*****Fax Medical Status to Corvel at (866) 449-6187 and Risk Management at (559) 713-3719*****

Medical Provider: Please examine and provide treatment to the employee deemed necessary as a result of the reported injury. County employees are required to keep their supervisor informed of their work status. Medical notes provided to the employee to give to their supervisor should not include private medical information such as diagnosis or treatment details such as prescriptions. Please specifically outline the work function to be modified or avoided so that modified or alternate work can be identified. If there are questions whether modified duty is available or regarding the facts of the injury call Tulare County Risk Management (contact information on page 2) for assistance.

Send the Doctor's First Report of Injury to:

Corvel Corporation
Policy Number: Permissibly Self Insured
P.O. Box 277550
Sacramento, California 95826
(916) 605-3800

County of Tulare
Risk Management
3530 W Mineral King Ave, Suite E
Visalia, California 93291
(559) 623-0280 Fax (559) 713-3719

County Medical Provider Network

Employee to Circle the facility they choose for Treatment

Visalia Locations:

Visalia Medical Clinic
5400 W. Hillsdale Dr.
Visalia, CA 93291
(559) 738-7542
M-F 8:30 a.m. – 11:30 a.m. and 2 p.m. – 5 p.m.
Sat 8 a.m. – 5 p.m., Sun 9 a.m. – 3 p.m.

Premier Walk-In Medical Clinic
4025 West Caldwell Ave
Visalia, CA 93277
(559)733-4505
M-F 8 a.m. – 7 p.m.
Sat 9 a.m. – 2 p.m., Sun 9 a.m. – 2 p.m.

Sequoia Prompt Care
1110 S. Ben Maddox, Suite B
Visalia, CA 9329
(559) 624-4800
M-F 9 a.m. – 8 p.m., Sat-Sun 10 a.m. – 6 p.m.
Radiology Services Not Available

Sequoia Prompt Care
820 S. Akers, Suite 100
Visalia, CA 93277
(559)624-6800
M-F 9 a.m. – 8 p.m., Sat-Sun 10 a.m. – 6 p.m.

Palm Occupational Medicine & Walk-In Clinic
1235 E. Noble Ave.
Visalia, CA 93277
(559) 625-1710
M-F 7:30 a.m. – 6 p.m.
(on call after 6 p.m. & weekends)

Reedley Location:

Job Care
936 G St. Suite B
Reedley, CA 93654
(559)638-5005
M-F 8 a.m. – 5 p.m.
Sat 8:30 a.m. – 12 p.m. (new injuries only)

Porterville Location:

Valley Prompt Care
876 W Grand Street
Porterville, Ca 93257
(559)781-3014
M-F 8 a.m. to 6 p.m.
(on call after 6p.m & weekends)

Tulare Location:

Palm Occupational Medicine & Walk-In Clinic
1068 N. Cherry Ave
Tulare, CA 93274
(559)684-7256
M-F 8 a.m. – 5:30 p.m. (On call after 5:30 p.m. & weekends)

Hanford Location:

Central Valley Comprehensive Care
869 W. Lacey Blvd
Hanford, CA 93230
(559)582-2929
M-F 8 a.m. – 5 p.m. (Call to confirm doctor is available)

Emergency Treatment Facilities:

Kaweah Delta Healthcare District
400 W. Mineral King
Visalia, CA 93291
(559)624-2215

Tulare Regional Medical Center
869 Cherry Street
Tulare, CA 93274
(559)688-0821

Sierra View District Hospital
465 W. Putnam Ave
Porterville, CA 93257
(559)784-8885

I decline medical treatment at this time.

Employee's Name: _____

Signature: _____ Date: _____

Risk Management Contacts for Workers' Compensation
Tami Tharp – Leave Analyst – Modified Duty or questions about complex Leaves 623-0292
Nancy Chavira – Leave Analyst – Modified Duty or questions about complex leaves 623-0296
Karen Lara – Risk Management Technician – Workers' Compensation 623-0293

To obtain more information about Workers' Compensation you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (559)445-5355. For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

Revised 10/26/15

RECEIPT OF DWC-1
Workers' Compensation Claim Form and Notice of Potential Eligibility

I hereby acknowledge that I have received an EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS form (DWC-1)

DATE REQUESTED by Employee:_____DATE RECEIVED by Employer:_____

DATE OF INJURY:_____

PRINT NAME:_____

DEPARTMENT:_____

SIGNATURE:_____

To obtain more information about Workers' Compensation you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (559)445-5355. For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

----------This section to be completed by Supervisor----------

Date of Employer's Knowledge of Injury:_____

TIME:_____

SIGNATURE OF SUPERVISOR:_____

SUPERVISOR PHONE NUMBER AND/OR EXT:_____

SUPERVISOR REPORT OF EMPLOYEE ILLNESS OR INJURY

1. EMPLOYEE NAME | 2. DEPARTMENT/AGENCY | 3. WORK LOCATION

4. JOB TITLE | 5. SEX | 6. DATE | TIME OF DAY ___/___/___ ___ am/pm | PLACE OF INJURY OR ILLNESS

7. TIME SHIFT BEGAN ___ am /pm | 8. SUPERVISOR ON DUTY AT TIME OF INJURY/ILLNESS | 9. DATE REPORTED ___/___/___

10. NATURE OF INJURY OR ILLNESS | 11. BODY PART(S) AFFECTED

12. WHAT WAS EMPLOYEE DOING WHEN INJURED? GIVE DETAILED EXPLANATION

13. DID AN UNSAFE CONDITION CONTRIBUTE TO THE INJURY? YES / NO EXPLAIN

14. DID EMPLOYEE COMMIT AN UNSAFE ACT? YES / NO EXPLAIN

15. TYPE OF MACHINERY / EQUIPMENT INVOLVED IN INJURY

15a. DEFECTIVE? YES / NO IF YES, PRESERVE EQUIPMENT/MACHINERY IN SECURE AREA

16. OTHER PERSONS INVOLVED? YES / NO GIVE NAMES, JOB TITLES, TELEPHONE NUMBERS, (USE ATTACHMENTS, IF NECESSARY)

17. ANY WITNESSES? YES / NO GIVE NAMES, JOB TITLES, TELEPHONE NUMBERS, (USE ATTACHMENTS, IF NECESSARY)

18. FACTORS THAT COULD HAVE CONTRIBUTED TO THE INJURY/ILLNESS:
____Not using available safety equipment ____Safety equipment not available ____Safety rule/practice violated ____Fatigue
____Inattention ____Inadequate instructions/training ____Improper attitude ____Lack of knowledge or skill ____Other

18a. DATE OF LAST TRAINING ON THIS TOPIC ___/___/___/___

19. MEDICAL ATTENTION REQUIRED? | 20. SOUGHT IMMEDIATELY? | 21. IF LATER, WHEN?

22. NAME AND ADDRESS OF DOCTOR/CLINIC/HOSPITAL

23. DID EMPLOYEE LOSE A FULL SHIFT FROM WORK? 24. HAS EMPLOYEE RETURNED TO WORK?

25. DATE RETURNED ___/___/___/___

26. WHAT HAVE YOU DONE, AS A SUPERVISOR, TO PREVENT SIMILAR INJURIES? MUST BE COMPLETED.

SUPERVISORS PRINTED NAME | SIGNATURE | DATE

Revised 10/15

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
6. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

PLEASE TAKE THIS INSERT TO THE PHARMACY

Injured Worker's First Fill Information Sheet

Injured Worker Name: _____ **Social Security #:**_____

Date Of Injury:_____

Dear Injured Worker,

On your first visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Worker's Compensation prescriptions, based on the established parameters by **County of Tulare FF**. With the CorVel CorCareRx program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Information Sheet to the pharmacy. You should not incur any costs or co-payments at the pharmacy and will allow up to a **14** day supply of medications.

Dear Pharmacist,

Please use the Injured Worker's (SSN+MMDDYYYY) as their 17 digit Identification number when entering the following information to process an online claim to CorVel on behalf of **County of Tulare FF** injured workers:

BIN: **004336**
PCN: **ADV**
RxGrp: **RXFFWC644**

Pharmacies can contact CorVel **Pharmacy Help Desk** at (800)563-8438 for assistance with claims processing. The Pharmacy Help Desk is available 24 hours a day, 7 days a week for your convenience.

There are 70,000 Participating Pharmacies in the CorVel Network. Below is a sample listing.

Bi-Lo Pharmacy	Fred's Pharmacy	Marsh Drugs	Safeway Pharmacy
Brooks Pharmacy	Fry's Pharmacy	Medical Arts Pharmacy	Sav-On Drug Store
Brookshire Pharmacy	Giant Eagle Pharmacy	Medicap Pharmacy	Schnuck's Pharmacy
City Market Pharmacy	Happy Harry's	Medicine Shoppe	Shop N' Save
CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Snyder's Drug Store
CVS	Hy-Vee Pharmacy	Minyard Pharmacy	Target Pharmacy
Discount Drug Mart	Ingles Pharmacy	NeighborCare	Thrifty Drug Store
Drug Mart	Kash N' Karry	Osco Drug	Tom Thumb Pharmacy
Duane Reade	Kerr Drug	Pathmark Pharmacy	United Drugs
Fagan Pharmacy	King Soopers	Payless Pharmacy	Von's Pharmacy
Family Drug	K-Mart Pharmacy	Price Choppers	Wal-Mart Pharmacy
Farmer Jack	Kroger Pharmacy	Publix Pharmacy	Walgreens Pharmacy
FarmFresh	Longs Drug Store	Raley's Drug Center	Wegman Pharmacy
Food Town	Marc's Pharmacy	Rite Aid Pharmacy	Winn Dixie Pharmacy

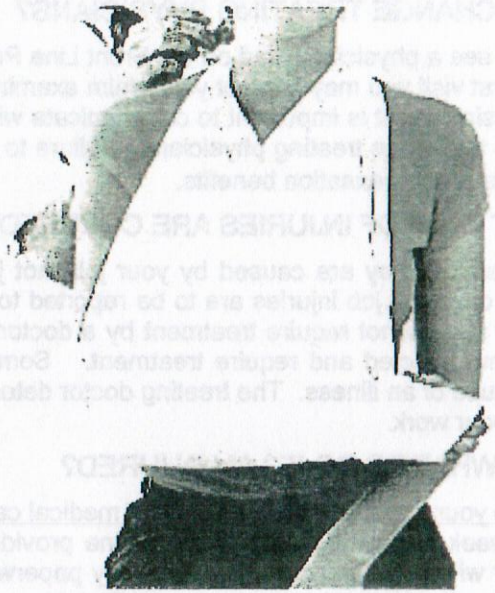
WORKERS' COMPENSATION CLAIM PROGRAM
SALARY INTEGRATION

Integrated Benefit Program

The County will integrate accumulated sick, vacation, or compensatory time off (CTO) hours while you are receiving temporary disability benefits. Sick vacation or compensatory time off hours will be charged only for the portion of salary difference between the workers' compensation temporary disability benefit amount and your full salary. The County's third party claim administrator works directly with payroll to verify the hours available. The County will issue your check on the normal bi-weekly pay date. Once sick, vacation, or compensatory time off hours are exhausted temporary disability benefits will be issued directly from the third party claims administrator.

Law Enforcement Safety Personnel

Law Enforcement and Safety personnel will receive a maximum of 52 weeks of 4850 pay. After 4850 pay is exhausted the County of Tulare will integrate accumulated sick, vacation, or compensatory time off hours while you are receiving temporary disability benefits. Sick vacation or compensatory time off hours will be charged only for the portion of salary difference between the workers' compensation temporary disability benefit amount and your full salary. The County's third party claims administrator works directly with payroll to verify the hours available. The County will issue your check on the normal bi-weekly pay date. Once sick, vacation, or compensatory time off hours are exhausted temporary disability benefits will be issued directly from the third party claims administrator.



Workers' Compensation Benefits Booklet

New Employee Orientation

Risk Management Division

3530 West Mineral King, Suite E

Visalia, California 93291

(559) 623-0280

Risk Management Division

3530 West Mineral King, Suite E

Visalia, California 93291

(559) 623-0280

Workers' Compensation Benefits

Sustaining an injury or illness on the job, whether slight or serious, is an unpleasant experience for anyone. In addition to the injury itself, you may have worries about medical treatment and financial loss. We hope that this handout will help eliminate some of those worries.

The California Workers' Compensation Law requires every employer to provide its employees with Workers' Compensation coverage. This coverage guarantees prompt and automatic benefits to employees injured on the job or who incur a job-related illness. Benefits are in the form of medical care, disability payments and may include vocational rehabilitation benefits.

The County of Tulare is self insured for its Workers' Compensation program. CorVel Corporation administers the County's Compensation Benefits Program.

WHO IS ELIGIBLE FOR COVERAGE?

All County employees have protection under the Workers' Compensation Law, including part-time and temporary workers. Volunteers are also eligible for coverage.

WHEN AM I ELIGIBLE FOR COVERAGE?

Workers' Compensation coverage begins the first minute you are on the job and continues any time you are working while in the course and scope of employment. You do not have to be employed for a certain length of time, nor do you have to earn certain amount of wages before you are protected.

IF I AM INJURED, HOW DO I APPLY FOR THE BENEFITS?

Upon reporting an injury, and confirmation that you sustained a compensable work-related injury, benefits are automatic and are applied according to State Law. It can take up to 90 days to determine eligibility for lost time benefits. You are entitled to medical care immediately from the first date of your injury.

You should report your injury to your immediate supervisor. Your supervisor will then submit a "Supervisors Report of Employee Injury/Illness", and give you an "Employee Claim form" (DWC Form 1) to complete. You must complete a claim form (DWC-1) to initiate the process of filing a claim.

DO I NEED TO FILL OUT ANY FORMS?

Yes, you are responsible to complete the employee section of the Employee's Claim for Workers' Compensation Benefits Form. You must complete this form as soon as possible to protect and enforce certain rights and privileges you have available under California's Workers' Compensation Laws. After completing this form, return it to your supervisor, or mail it to Tulare County Risk Management, 3530 West Mineral King Suite E, Visalia California 93291. If you're placed on temporary disability, an "Initial Lost Time Form" must be completed by you documenting the election of leave to be integrated with your workers' compensation benefits. Failure to complete the necessary forms may jeopardize your rights or cause delay in the issuance of benefits.

CAN I GO TO MY OWN DOCTOR?

Yes, if you have a valid pre-designation on file your personal physician can treat you for a work related injury. You must notify the County of Tulare in writing by completing the Pre-Designation of Personal Physician Form before an injury occurs. The doctor which you pre-designate must have previously directed your medical treatment and retain your medical records, including your medical history. But, if your doctor is not immediately available, don't wait. Go to one of the listed facilities for immediate attention. If you become dissatisfied with the medical treatment, you may request a change in medical providers by contacting your claim examiner. A change in medical providers or a second opinion must be authorized in advance.

CAN I CHANGE TREATING PHYSICIANS?

Yes. You must first see a physician listed on the Front Line Provider list for the initial visit. After the first visit you may contact your claim examiner and request a change of treating physicians. It is important to communicate with your claim examiner when you wish to change treating physicians. Failure to do so may result in a delay of your workers' compensation benefits.

WHAT TYPE OF INJURIES ARE COVERED?

All injuries are covered if they are caused by your job, not just serious accidents, but even minor ones. All job injuries are to be reported to your supervisor, even if they are minor and do not require treatment by a doctor. A slight cut on your finger may become infected and require treatment. Sometimes there are questions about the cause of an illness. The treating doctor determines if the injury/illness is related to your work.

WHAT TO DO IF I AM INJURED?

Report your injury to your supervisor immediately. If medical care is needed you will be authorized to seek care with one of the frontline providers listed on this form. Your supervisor will then complete the necessary paperwork. Should you have any questions regarding the claims process, call Risk Management at 623-0280.

FRAUD

Anyone who knowingly files or assists in the filing of a false workers' compensation claim may be fined up to $150,000 and sent to prison for up to five years (Insurance Code Section 1871.4).

To obtain more information about Workers' Compensation you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (559)445-5355. For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

IF THE DOCTOR TELLS ME TO TAKE OFF WORK, WHAT HAPPENS TO MY INCOME AND BENEFITS?

It is your responsibility to advise your supervisor of your work status. It will be necessary that you provide a medical note from your primary treating physician immediately if you should become disabled or placed on light duty. Workers Compensation law provides for partial replacement of lost wages in the form of temporary disability benefit. These payments may be provided as long as the primary treating physician reports you are unable to work due to a work related injury. There may be further payments provided after you return to work if the doctor reports that you have a permanent impairment or restriction as a result of a work related injury.

Your health benefits will continue to be in effect as long as you receive temporary disability payments or Labor Code 4850 payments. Integration of comp time leave or vacation/sick leave is available only while on Temporary Disability, as long as there is leave time available to integrate. You must continue to be a County employee for this benefit.

Time taken off from work for doctor's appointments and physical therapy is not reimbursed by temporary disability payments. Lost time is deducted from your sick leave unless your department allows you to make up time. Tulare County has a policy that employees must use sick leave for all medical appointments. An employee will not be eligible for the vacation donation program if they are receiving Workers Compensation or Labor Code 4850 payment.

HOW MUCH ARE TEMPORARY DISABILITY PAYMENTS AND WHEN ARE THEY PAID?

Temporary disability payments begin after the first three days you are off work due to a work related injury unless you are hospitalized. If hospitalized you will be eligible for temporary disability immediately. Your salary will continue during this three-day period with the use of any vacation/sick leave you may have accrued. After this three-day period, the County will continue to use your sick leave to supplement your workers' compensation benefit payments for the length of time you continue to be off work or until you exhaust your accruals. Once your accruals exhausted, you may integrate compensatory time off if you have elected to on the Initial Lost Time Form

Once your accruals are exhausted, CorVel Corporation will issue temporary disability benefit directly to you until you are no longer temporarily totally disabled. Report duplicate payments immediately to avoid overpayments that must be reimbursed.

"EXCEPTION TO ABOVE REGARDING L.C. 4850 BENEFITS"

Law Enforcement Officers who are disabled are entitled to a leave of absence while so disabled without loss of salary or waiting period in lieu of temporary disability payments or maintenance allowance payments. However, there is a one year statue of limitations for these benefits.

WHAT ABOUT F.M.L.A./C.F.R.A. AND WORKERS' COMPENSATION BENEFITS?

The time off work due to a job related injury or illness will run concurrent with Family or Medical Leave (FMLA)/California Family Rights Act Leave (CFRA).

WHAT IF I CAN RETURN TO LIGHT OR MODIFIED DUTY?

The County of Tulare will not discriminate against any qualified individual with a disability, and shall make reasonable accommodations that will enable the employee to perform the essential functions of an available job, unless the accommodation would impose an undue hardship on the County's operations. If you are released to perform modified work, give your supervisor a note from your doctor which shows your work restrictions. If your supervisor is unable to determine whether an accommodation is possible, the Disability Management Specialist will assist.

WHAT IF MY CLAIM IS REJECTED?

Most job injury claims are handled routinely. The benefits are statutory. If you have questions regarding your entitlement to benefits, contact County Risk Management or your claim examiner. They will attempt to provide you with the information and explanation you need. You may also contact the State of California Office of Information and Assistance. The number for the Fresno office is (559) 445-5355.

If you choose to consult with legal counsel, he/she may suggest that an Application for Adjudication be filed with the Workers' Compensation Appeals Board. The Appeals Board is a court of law. You may represent yourself, or you may have counsel represent you. If counsel represents you, his/her fee is fixed by the Appeals Board and is deducted from any benefits awarded you by the Appeals Board.

WHAT IF MY INJURY REQUIRES LIFETIME MEDICAL TREATMENT OR PERMANENTLY DISABLES ME?

If a doctor determines the injury requires lifetime medical treatment or causes a permanent disability and limits your physical ability to perform as you did prior to the injury, you may be entitled to an award for Future Medical Care or a permanent disability benefit. The amount of the award is usually paid over a set number of weeks or months. You or the County have a right to contest the permanent disability rating. (559) 445-5355

WHO PAYS FOR MEDICAL TREATMENT?

The doctor or hospital will bill the County through CorVel. This includes the cost of the doctor, hospital, x-ray, crutches, lab work and other services and supplies the doctor prescribes to treat your injury. You can also be reimbursed for mileage to and from any medical facility for treatment. Submit a statement to CorVel showing the dates of treatment and the mileage involved. You should not incur any out of pocket costs.

WHEN AM I ELIGIBLE FOR A REHABILITATION PROGRAM?

If you are unable to return to work as the result of a work-related injury, you may be eligible for a Supplemental Job Displacement Voucher. First the County will engage in the interactive process to seek a reasonable accommodation on a permanent basis. If this is not possible, you may be entitled to a Supplemental Job Displacement Voucher. If you have any questions regarding your entitlement to workers' compensation benefits for your injury, please contact any of the following:

CorVel Corporation
P.O. Box 277550
Sacramento, California 95827
(916)-605-3800

County of Tulare/Risk Management Division
3530 West Mineral King Suite E
Visalia, CA 93291
(559) 623-0280

WHAT DO I TELL THE DOCTOR OR HOSPITAL WHEN I GET TO THE MEDICAL FACILITY?

Simply provide the receptionist with the Medical Treatment Authorization Form which has been signed by your supervisor. Advise the doctor's office or hospital emergency room that your injury occurred on the job and the circumstances regarding your injury. The medical provider may ask for the name of your employer or insurance carrier. You should advise the medical provider of your status as a County employee and the medical reports/bills should be sent to:

CorVel Corporation
P.O. Box 277550
Sacramento, California 95827
(916)-605-3800

WHERE DO I GO FOR MEDICAL TREATMENT?

Dial 911 for an Emergency

Clinics—Visalia

Visalia Medical Clinic
5400 W. Hillsdale Dr.
Visalia, CA 93291
(559) 738-7542

Palm Occupational Medicine & Walk In Clinic
235 E. Noble Ave.
Visalia, CA 93277
(559) 625-1710

Sequoia Prompt Care
1110 S. Ben Maddox, Suite B
Visalia, CA 93291
(559) 624-4800

Premier Walk-In Clinic
4025 W. Caldwell Ave
Visalia, CA 93277
(559) 733-4505

Clinic—Tulare

Palm Occupational Medicine & Walk In Clinic
1068 North Cherry Avenue
Tulare, CA 93274
(559)684-7256

Clinic—Porterville

Valley Prompt Care
876 W. Grand Street
Porterville, CA 93257
559) 781-3014

Clinic—Hanford

Central Valley Comprehensive Care
869 W. Lacey Blvd.
Hanford, CA 93230
(559) 582-2929

Clinics—Reedley

Occupational Medical Associates
936 G Street, Suite B
Reedley, CA 93654
(559) 637-1900

Job Care
1311 11th Street
Reedley, CA 93654
(559) 638-5005

Hospitals

Kaweah Delta Healthcare District
400 W. Mineral King
Visalia, CA 93291
(559) 624-2215

Sierra View District Hospital
465 W. Putnam Ave.
Porterville, CA 93257

Tulare Regional Medical Center
869 Cherry Street
Tulare, CA 93274
(559) 688-0821