

WORKERS' COMPENSATION: THE ON-SITE COUNTY REPRESENTATIVES/ INJURY REPORTING

Tony Taras

**Workers' Compensation Program
CEO Risk Management Branch**

County Code 5.31.050

Workers' Compensation System

1. Report, investigate, and adjust claims.
2. Determine compensability and pay benefits.
3. Collect and report statistical data.
4. Establish and review reserves.
5. **“Control...workers’ compensation costs consistent with full provision of benefits under the law.”**

TPA CONTRACTS – TECHNICAL EXHIBIT I

WORKERS' COMPENSATION PROGRAM

“The primary objective of this program is to provide all workers’ compensation benefits required under State law to injured County employees on a timely basis, at the least possible cost to the County.”

YORK (UNIT 1)

MANAGERS: MATTHEW HOWARD

(626) 463-6169

matthew.howard@yorkrsg.com

SHERI LAWRENCE

(626) 463-6170

sheri.lawrence@yorkrsg.com

YORK (UNIT 1)

OSCRs:

ROSE BLOOM

(626) 463-6182

rbloom@ceo.lacounty.gov

PAM KENNEDY

(626) 463-6183

pkennedy@ceo.lacounty.gov

TRISTAR (UNIT 2)

MANAGER: OLA OSIFESO
(714) 543-0700 ext 1152
ola.osifeso@tristargroup.net

OSCR: TONI VU
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tvu@ceo.lacounty.gov

INTERCARE (UNIT 3)

MANAGER: LANAI PHOUNG PHUN

(866) 221-2968 ext 430

lphoungphun@intercareins.com

OSCRs: JOE CARRILLO

(866) 221-2968 ext 422

jcarrillo@ceo.lacounty.gov

PAIGE PATTERSON

(866) 221-2968 ext 421

epatterson@ceo.lacounty.gov

SEDGWICK (UNIT 4)

MANAGER: FERNANDO PLA

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fernando.pla@sedgwickcms.com

OSCR: TONY TARAS

(213) 351-6405

ataras@ceo.lacounty.gov

ON-SITE COUNTY REPRESENTATIVE

- “The Quality Assurance Evaluator is a County employee designated as an agent for the County responsible for monitoring the Contractor’s performance, approving over limit payments, advising and training third party administrator staff in County payroll systems and other County procedures.” At times this employee may be referred to as the On-Site County Representative (OSCR).

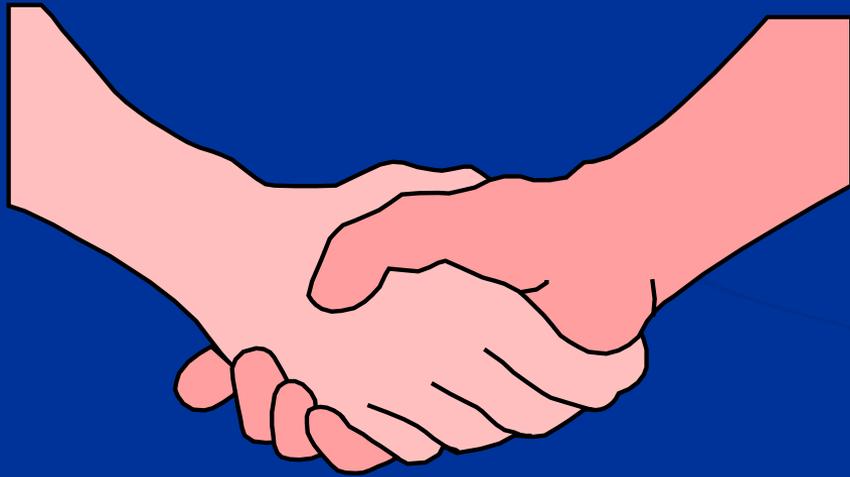
DUTIES OF THE OSCR

- Review all delayed claims at 30/60/90 day intervals
- Approve all litigation referrals to County Counsel
- Approve all award payments
- Approve all payments over \$7,500.00
- Provide training to TPA staff

DUTIES OF THE OSCR

- Assist TPA staff on balancing of complex cases
- Analyze claims and provide settlement recommendations and authority
- Address questions and concerns of injured workers, County departments, and defense attorneys
- Attend claim reviews
- Conduct annual audit of the TPA's

LIAISON BETWEEN DEPARTMENTS AND THIRD PARTY ADMINISTRATORS



CLAIM REVIEWS

- Reviews should be held at least quarterly with OSCRs, CEO RTW personnel, Departmental RTW personnel, Loss Control, and County Counsel.
- Don't overload! If necessary, schedule more frequent claim reviews.

CLAIM REVIEWS

File Selection:

- Choose files with complex claims or RTW issues.
- Get input from your TPAs, OSCRs, and Counsel.
- “Out of service” does not mean “out of sight, out of mind”!

CLAIM REVIEWS

What we need from you:

- Information about any RTW efforts that have been made
- Information about any disciplinary action being taken against the injured worker (unless confidential)
- Information about any other action the injured worker is taking against the County (unless confidential)
- Type of retirement plan
- Out of service date and termination reason, if any

WORK RESTRICTION LETTERS

TEMPORARY WORK RESTRICTION LETTERS

- Issued based on temporary work restrictions provided by primary treating physician, AME, and/or State Panel QME prior to finding of permanent and stationary.
- Sometimes referred to as interim or transitional.
- There may be multiple versions due to the changes in the injured worker's medical condition.
- The TPA is required to issue the letter within 10 days of receipt of applicable medical documentation.

PERMANENT WORK RESTRICTION LETTERS (PRIOR TO SETTLEMENT)

- Based on permanent and stationary finding of the primary treating physician, AME, and/or State Panel QME.
- There may be more than one version based on differing medical opinions.
- The TPA is required to issue the letter within 10 days of receipt of applicable permanent and stationary medical reports.
- The 15% increase/decrease under LC 4658 is usually determined at this juncture.

PERMANENT WORK RESTRICTION LETTERS (AFTER SETTLEMENT)

- Based on work restrictions agreed upon by parties and included in settlement documents.
- The TPA is required to issue letter within 10 days of receipt of settlement documents.
- In most cases, this is the final work restriction letter the TPA will issue on an individual claim.

QUESTIONS?

Overview of Workers' Compensation and Injury Reporting

Emergency injury reported



CALL 911

Emergency injury reported

cont...

- Once the situation is stable, you should:
 1. Provide a DWC1 Claim Form to employee, complete the Employer's Report of Injury (5020) and call into the Toll-Free number within 24 hours.
 2. Complete the Job Description form.

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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



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

SAVE PRINT CLEAR

WORKERS' COMPENSATION CLAIM FORM (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.

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

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

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 "felonía".

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

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

Employee: 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 propée 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

7/1/04 Rev.

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY/ILLNESS (5020 FORM)

TITLE OF CALIFORNIA EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in legible type (if possible) Mail two copies to:		OSHA CASE NO.	
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 paying 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.		FATALITY <input type="checkbox"/>
1. FIRM NAME	2. Employee No.	Please do not use this column			
3. MAILING ADDRESS (Number, Street, City, Zip)	2a. Phone Number	CASE NUMBER			
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)	2b. Department No.	OWNERSHIP			
4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.	5. State unemployment insurance acct. no.	INDUSTRY			
6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't. Specify _____	OCCUPATION				
7. DATE OF INJURY (month/day/yr)	8. TIME INJURY/ILLNESS OCCURRED	9. TIME EMPLOYEE BEGAN WORK	10. # EMPLOYEE(S) DATE OF DEATH (month/day/yr)		
11. UNABLE TO WORK FOR AT LEAST ONE FULL CALENDAR DAY OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. DATE LAST WORKED (month/day/yr)	13. DATE RETURNED TO WORK (month/day/yr)	14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		
15. PAID FULL DAILY WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF ILLNESS (month/day/yr)	18. DATE EMPLOYEE WAS PROVIDED CLAIN FORM (month/day/yr)		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop		21. Other Workers Injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Azebylers, welding torch, farm tractor, scaffold					
24. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, feeding boxes onto truck					
25. 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, _____					
THIS FORM IS COMPLETED BY CALLING THE TOLL FREE INJURY REPORTING NUMBER					
27. Name and address of physician (number, street, city, zip)		27a. Phone Number			
28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, name and address of hospital (number, street, city, zip)		27b. Phone Number			
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)(4)-(14) & 14300.38(b)(2)(B). Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.38(b)(2)(B).		27c. Employee treated as emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
29. EMPLOYEE NAME		30. SOCIAL SECURITY NUMBER	31. DATE OF BIRTH (month/day/yr)		
32. HOME ADDRESS (Number, Street, City, Zip)		31a. PHONE NUMBER			
34. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		36. DATE OF HIRE (month/day/yr)	
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37a. EMPLOYMENT STATUS: <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		37b. ARE YOU A MEGAFLEX PARTICIPANT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. GROSS WAGES/SALARY \$ _____ per _____		38. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tip, meal, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Completed by (type or print)		Signature & Title		Date (month/day/yr)	
<small>Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.38), to others for the purpose of prosecuting 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.</small>					

JOB DESCRIPTION FORM

JOB DESCRIPTION

Name:

Employee #: 000000

Department #:

Job Classification:

JOB SUMMARY/DESCRIPTION OF TASKS

TOOLS, EQUIPMENT AND MACHINERY

PHYSICAL DEMANDS – List duration, frequency, and tasks performed

- Sitting
- Walking (distance)
- Standing
- Bending
- Squatting
- Climbing (height)
- Kneeling

JOB DESCRIPTION FORM

- Crawling
- Twisting
- Lifting + Carrying (weight, objects)
- Hand Use (right or left hand dominant)
 - ✓ Simple Grasping
 - ✓ Power Grasping
 - ✓ Fine Manipulation
 - ✓ Pushing and Pulling
 - ✓ Reaching (above or below shoulders)

STRESS FACTORS

- Amount of work performed (caseload, production standards, overtime)
- Interpersonal Contacts (clients, superiors, subordinates, co-workers, public)
- Other?

Supervisor Signature

Date

Employee Signature

Date

NON-EMERGENCY INJURY REPORTED

➔ If Employee Declines Treatment:

1. Employee must complete the Employee's Statement Declining Treatment form. A copy of the form must be sent to the RTW Coordinator or Personnel.
2. Employee must sign Receipt of Employee Packet, and be given the packet.

Employee's declining medical treatment FORM

**County of Los Angeles
Employee's Statement Declining Medical Treatment**

Employee's Name _____ Department _____

Although I have been offered first-aid medical treatment /advice,
in connection with my injury, I am declining the offer for the following
reason(s):

Signed- Supervisor or Other
County Official

Signed- Employee Date

Receipt of employee packet

RECEIPT OF EMPLOYEE PACKET

This packet should be given to the employee when a potential work related accident or injury has been reported, but the employee refuses to complete the forms at the time of reporting. By signing in the spaces below, the employee and supervisor acknowledge that the employee has received the Employee Packet for use throughout the course of this workers' compensation claim. This packet is a key component of the County of Los Angeles Return to Work Program and should be completed in a timely manner. It provides the employee with critical information regarding the filing of an industrial injury.

The Supervisor should retain this document in the employee's file.

Employee's Signature

Print Name

Date

Supervisor's Signature

Print Name

Date

Employee's Statement Declining Medical Treatment
Workers' Compensation Claim form (DWC 1)
Employee's Report of Accident
Treatment Referral Slip
Treating Physician's Letter
Patient Status Report
Job Description
Employee's Report of Occupational Injury or Illness (5020 form)
First Alert Form
Weekly Telephone Call Verification Sheet
Work Hardening Transitional Assignment Agreement

Employee seeks treatment

- Review the Employee's Guide for Injury Reporting with the employee.
- Complete the Injury Reporting forms with the employee. The packet must contain the four forms below:
 1. The completed Treatment Referral Slip
 2. The completed Treating Physician's letter (for physical injuries only)
 3. A copy of the blank Patient Status Report
 4. A copy of the completed Job Description should be included in the Medical Provider Packet.

Send the four documents with the employee to the Pre-designated physician or ITC, as applicable.

Treatment referral slip FORM

County of Los Angeles
Return to Work Program
TREATMENT REFERRAL SLIP
To be completed by Supervisor

Date	
Doctor/Medical Facility:	
Address:	
Phone:	Fax:

This form authorizes you to administer initial treatment to the following employee who has reported an injury which may be work related.

Employee Name:	Emp. #:
Date of Injury:	Job Title:
Department Name and Number:	
Employee's Work Address:	

Workers' Compensation Third Party Administrator:	
TPA Address:	
	Phone:

Employee Supervisor:	Phone:
Return To Work Coordinator:	Phone:

INSTRUCTIONS TO MEDICAL PROVIDER

1. Complete Patient Status Report and give to Employee to return to Supervisor.
2. Send the original completed Doctor's First Report of Injury to the Third Party Administrator listed above.
3. Fax a copy of the completed Doctor's First Report of Injury to [] at [] - [] - [] or mail to [], CA [].
4. Call the Third Party Administrator at the number listed above immediately to request any of the following during the initial visit:
 - Consultation
 - Hospitalization
 - Additional Diagnostic Testing
 - Physical Therapy
5. Call [] at [] - [] - [] if you have any questions.
6. Send all Medical Bills to the Third Party Administrator listed above.

Treating physician's letter

(Physical injuries only)

County of Los Angeles
Return to Work Program
TREATING PHYSICIAN'S LETTER: Physical Injury

(date)

To: Initial Treatment Physician

Re: Injured Worker: _____
(Print name of Employee)

- Our employee has been sent to your office for medical treatment of an injury that may be work-related.
- Enclosed is the job description of the injured worker's duties. We would request that a review of his/her job description be made prior to making a decision regarding recovery limitations/work restrictions.
- The County of Los Angeles has a Return-to-Work Program and will attempt to modify the current position or place an injured worker into a Work Hardening/Light Duty Assignment. If you have any questions call _____ at _____.
- Please use the enclosed Patient Status Report to outline the recovery limitations/work restrictions, if any, recommended at this time, as well as the treatment plan.
- All treatment is pursuant to ACOEM Guidelines, and must comply with DWC Regulations.
- Payment is according to fee schedule pursuant to Labor Code section 5307.1 and 8 California Code Regulation 9789.10.
- Reporting must adhere to the requirements of the Division of Workers' Compensation.

Should you have any questions or need to review additional information regarding our program, please contact the Los Angeles County Chief Administrative Office (CAO) Disability Administration at (213) 351-6433.

Thank you for your full cooperation.

The Patient Status Report needs to be completed prior to the employee leaving your office.

Patient status report FORM

(Physical injuries only)

County of Los Angeles
Return to Work Program
PATIENT STATUS REPORT: Physical Injury
 To be completed by Physician

Employee Name:	Emp.#
Claim Number:	Date of Injury:
Third Party Administrator:	Date of Visit:

"Yes, I have reviewed the employee's Job Description prior to completing work status information."
 (Physician, please check box.)

WORK STATUS	
Check appropriate box and enter date	
<input type="checkbox"/> Released to Usual and Customary Position WITHOUT Limitations on:	<input type="checkbox"/> Expected Release to Usual and Customary Position on:
<input checked="" type="checkbox"/> Released to Light Duty Assignment with the Work Restrictions listed below on:	<input type="checkbox"/> Expected Release to Light Duty Assignment on:
<input checked="" type="checkbox"/> Totally Temporarily Disabled until:	<input type="checkbox"/> Released from Care on:

RECOVERY LIMITATIONS/WORK RESTRICTIONS

Indicate limitations related to the following activities:	Check If No Limitations
Sitting: Max ___ 2 hrs. ___ 4 hrs. ___ 6 hrs. per day Other/notes:	
Standing: Max ___ 2 hrs. ___ 4 hrs. ___ 6 hrs. per day Other/notes:	
Walking: Max ___ 2 hrs. ___ 4 hrs. ___ 6 hrs. per day Other/notes:	
Lifting/Carrying:	
Employee can lift/carry up to ___ pounds infrequently.	
Employee can lift/carry up to ___ pounds occasionally.	
Employee can lift/carry up to ___ pounds frequently.	
Employee cannot lift/carry more than ___ pounds.	
Bending:	
Squatting:	
Kneeling/Crawling:	
Climbing:	
Reaching:	
Pushing/Pulling:	
Gripping/Grasping:	
Repetitive Hand Use:	
Fine Finger Manipulation:	
Other:	
Can employee have contact with the public? <input type="checkbox"/> Yes <input type="checkbox"/> No.	

TREATMENT PLAN

Follow Up Appointment On: _____

Medication: _____

Physical Therapy: _____ time(s) per week for _____ weeks

Physician's Signature:	Date:
Physician's Name:	Fax Number:
Phone Number:	

EMPLOYEE SEEKS TREATMENT

CONT...

- Ask the employee if they have pre-designated a treating physician.
- If they have not, send them to the Medical Provider Network (MPN) Initial Treatment Center (ITC).
A list of those centers can be obtained on the County's MPN website at:
<http://ceo.lacounty.gov/mpn>

PREDESIGNATION OF PERSONAL PHYSICIAN FORM

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

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

(street address, city, state, ZIP)

(telephone number)

Employee Name (please print):

Employee's Address:

Employee's
Signature

Date:

Physician: I agree to this Predesignation:

Signature: _____ Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

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

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 March 1, 2007)

EMPLOYEE SEEKS TREATMENT

CONT...

- Provide the DWC1 Claim Form to the employee and complete the Employer's Report (5020) form. The injury must be called into the **Toll-Free** number within 24 hours upon notice of the injury.
- Call the Toll-Free number and report the injury.

In some departments, the main RTW Unit staff calls in the injury, in others the supervisor or location designee calls it in.

MPN Initial Treatment Centers (ITC)

- ➔ If Employee has not Pre-designated their personal treating physician, the work location Supervisor or designee must direct them into the County's Medical Provider Network (MPNs), via an Initial Treatment Center (ITC).

Review of employee responsibilities

- ➔ Complete DWC-1 Employee Claim Form
- ➔ Complete Employee's Report of Accident
- ➔ Return the Completed forms to their supervisor/including all Medical Certifications from the treating physician

Questions???

