DEPARTMENT OF BUILDING INSPECTION
INJURY CHECKLIST

For emergency treatment - take employee to nearest emergency room or call 911.

The forms listed below must be completed by the supervisor in the event of an accident. Packets of blank forms are available from your Safety Coordinator.

After providing for initial first aid care to employee:

- ☐ Supervisor gives blank **Workers' Compensation Claim Form (Form DWC 1)** to employee within 24 hours of notification of injury. If employee wants to file a claim, he/she completes and signs top portion of **Form DWC 1** and returns it to his/her supervisor. Supervisor then completes bottom portion of **Form DWC 1** and gives employee his/her copy of the completed form. Note: If employee declines to sign **Form DWC 1**, supervisor should complete **Supervisor's Report of Accident Investigation** and make a note that employee declines to file a claim at this time.

  Once a Form DWC 1 has been signed by an employee, it must be turned in to the Safety Coordinator immediately even if employee does not seek medical treatment or states that (s)he does not want to file a claim.

- ☐ Supervisor notifies Manager immediately of the injury.

- ☐ Supervisor conducts **Incident Investigation** immediately after the accident.

- ☐ Supervisor completes **Medical Authorization Form (MAF)** to authorize treatment at the designated treatment facility and transports the employee to the treatment facility. Initial treatment for work related injuries and illnesses must be at one of these clinics regardless of the employee designating his/her personal physician.

- ☐ Supervisor completes **Form 5020 – Employer's Report of Occupational Injury or Illness** on the day of the incident. **Form 5020's** completed by the injured employee are not acceptable.

- ☐ Employee provides Supervisor with completed **MAF** and/or Physician's Work Status Report after being treated. Employee must provide supervisor with a Physician's Work Status Report before an employee may return to work.

- ☐ If the Physician's Work Status Report recommends modified work, supervisor completes **Notification of Modified Work Assignment** and gives to Manager for approval.

- ☐ If there is a motor vehicle accident involved in the injury, the driver completes the **Equipment Accident Report.**

- ☐ Supervisor gives copies of all forms to Safety Coordinator.

- ☐ Notify CAL/OSHA Enforcement (415-972-8670) immediately if an employee is taken by ambulance to the hospital, is hospitalized for more than 24 hours for other than observation, or dies

CONFIDENTIAL - FOR THE USE OF THE CITY ATTORNEY

DEPARTMENT OF BUILDING INSPECTION
SUPERVISOR'S REPORT OF INCIDENT INVESTIGATION

Name of Employee:_____

Division: _____ Classification: _____ Job Title:_____

Date of Incident: _____Time of Incident: _____

Shift Start Time: _____Supervisor/Title: _____

Location of Incident: _____

Environmental Conditions: _____
(weather, lighting, etc.)

□ Injury
□ Illness
□ Near Miss
□ Vehicle

Witnesses: _____
Copy of statements attached? □ Yes □ No
Date Provided Form DWC 1: _____
Employee Declined to Complete Form DWC 1? θ Yes θ No

1. Give details of the incident: (who, what, where, when & how; include all information in detail and attach extra sheets, if needed)

   _____
   _____
   _____
   _____
   _____

2. Medical Attention: Describe the injury in detail, include part of the body and nature of injury:

   _____
   _____
   _____
   _____

   First Aid: □ Yes □ No If yes, what was done?_____
   _____
   _____

   Transported by Ambulance? □ Yes □ No _____
   Treated in Emergency Room? □ Yes □ No If yes, name & address _____
   Initial Treatment Facility? □ Yes □ No If yes, name & address _____
   _____
   Number of work days lost, if known: _____ Still off? □Yes □ No

3. Describe any property, equipment and/or vehicle damage: include property brand name, model, color and serial number:

   _____
   _____

4. Required Safety Equipment and Personal Protective Equipment (PPE) worn?
   □ Yes □ No
   List PPE worn:_____
   _____

5. Describe the unsafe act(s) or condition(s):
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

6. How can this incident be avoided in the future? Include Corrective Action Plan taken or to be taken to prevent reoccurrence. List responsible person(s) and completion dates:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

7. Is there a Code of Safe Practices available for the related procedure?
   □ Yes If yes, was it reviewed? □ Yes □ No
   □ No If no, should there be? □ Yes □ No

Supervisor's signature: _____ Date: _____

Manager's signature: _____ Date: _____

Distribution: Submit to Safety Coordinator

DEPARTMENT OF BUILDING INSPECTION
MEDICAL AUTHORIZATION FORM FOR INDUSTRIAL INJURY/ILLNESS

SUPERVISOR: COMPLETE THIS SECTION. PROVIDE TO EMPLOYEE TO GIVE TO TREATING PHYSICIAN.

EMPLOYEE NAME_____ SOC. SEC. NUM._____
DIVISION _____ DATE OF INJURY_____
JOB CLASS_____ JOB TITLE_____

This DBI employee has reported an industrial injury/illness and may require medical treatment. You are authorized to provide treatment to cure or relieve the effects of the injury/illness. Please complete the middle portion of this form and provide it to the employee immediately following his/her exam. Send the "Doctor's First Report" to the Intercare Insurance Services, P.O. Box 579, Roseville, CA 95661 (Phone 800-771-5454).

DBI policy provides modified work when available for industrially injured employees disabled from performing their usual and customary duties, depending on the physical restrictions of the employee. Please state specific work restrictions you believe must apply to return this employee to modified work, in the space provided below.

For more information regarding the specific job duties of this employee please contact the undersigned.

By:_____ Date:_____ Tel: ( )_____
(SUPERVISOR)

PHYSICIAN: COMPLETE THIS SECTION AND RETURN TO EMPLOYEE.

PHYSICIAN:_____
(PHYSICIAN, HOSPITAL, MEDICAL GROUP, PHYSICAL THERAPIST, ETC.)
ADDRESS:_____
TELEPHONE NO.:_____
SIGNATURE:_____ DATE:_____

WORK STATUS:

- ☐ Return to/continue full duty on (date)_____
- ☐ Unable to work from (date)_____ Through_____
- ☐ Released to Modified Work on (date)_____ Through_____

With the following restrictions:_____

_____

_____

Diagnosis:_____
Estimated release to full duty (date):_____

- ☐ Non-Industrial: Follow-up care with private medical provider.
- ☐ Physical therapy required: _____times per week for_____weeks.
- ☐ Discharged from care/no further follow-up required.
- ☐ **Return Appt. Date:**_____ **Time:**_____

EMPLOYEE: RETURN THIS FORM TO YOUR SUPERVISOR, IN PERSON:

- **Immediately after medical treatment, if prior to end of work shift; or**
- **At beginning of next shift, if after end of work shift; or**
- **Immediately by phone: call or fax information to your supervisor if hospitalized or physically unable to return to work.**

DESIGNATED MEDICAL TREATMENT FACILITIES

In the event of an industrial illness or injury, listed below are the Designated Medical Facilities. An employee's initial treatment for his/her injury or illness must be at one of these clinics regardless of selecting their own personal physician.

For injuries occurring during normal business hours:

St. Francis Treatment Room
1199 Bush Street, Suite 160
Hours: 7:30 A.M. to 5:30 P.M., Monday through Friday
Telephone: (415) 353-6305

AT&T Clinic- St. Francis Health Center (at the Ballpark)
24 Willie Mays Plaza
Hours: 7:30 A.M. to 5:00 P.M., Monday through Friday
Telephone: (415) 972-2249

Kaiser Occupational Health Clinic (Opera Plaza)
601 Van Ness Avenue, Suite 2008
(corner of Van Ness & McAllister, 2nd floor)
Hours: 8:30 A.M. to 5:00 P.M., Monday through Friday
Telephone: (415) 674-7000

California Pacific Medical Center - Davies Campus
Castro & Duboce Streets
Hours: 8:00 A.M. to 5:00 P.M.
Telephone: (415) 600-6600

US Healthworks
1893 Monterey Road, Suite 200
San Jose
Hours: 8:30 A.M. to 7:00 P.M., Monday through Friday
Telephone: (408) 288-3800

San Francisco International Airport Medical Clinic
Terminal 2, Boarding Area D
Hours: 8:30 A.M. to 7:00 P.M., Monday through Friday; 9:00 A.M. to 1:00 P.M., Saturday
Telephone: (650) 821-5600

Valley Care Occupational Health Clinic
5565 W. Los Positas Blvd
Pleasanton, CA
Telephone: (925) 416-3562

Sonora Regional Medical Clinic
1000 Greeley Rd
Sonora, CA 95370
Telephone: (209) 532-3161

For injuries occurring after normal business hours:

California Pacific Medical Center - Davies Campus, Emergency Department
Castro & Duboce Streets
Telephone: (415) 600-6600

Kaiser Permanente Medical Center Urgent Care Clinic
2238 Geary Blvd., 8th Floor S.E.
Hours: 5:00 P.M. to 9:00 P.M.
Emergency Department
2200 O'Farrell Street at Baker
Hours: 9:00 P.M. to 8:00 A.M.
Telephone: 833-8525

Saint Francis Memorial Hospital Emergency Department
1100 Bush Street, between Hyde and Leavenworth Streets
Telephone: 353-6300

San Francisco General Hospital Emergency Department
1001 Potrero Ave
Telephone: (415) 206-8111

Sonora Regional Medical Hospital
1000 Greeley Rd
Sonora, CA 95370
Telephone: (209) 532-3161

DEPARTMENT OF BUILDING INSPECTION
NOTIFICATION OF MODIFIED WORK ASSIGNMENT

DATE: _____

TO: _____Employee

FROM: _____Manager

SUBJECT: Modified Work Assignment

Based upon receipt and review of your physician's certification (copy attached) your physician diagnosed the following:

Date of Injury:_____

Injury:_____

Work restrictions:_____

_____

You are hereby assigned to modified work. **Modified duty shall not extend beyond 180 days. Previous Days on Modified Duty**_____

Modified work assignment is:_____

Dates:_____
From To

Location:_____

Schedule:_____

Duties:_____

_____

Note: **You must continue to bring Physician's Work Status Reports to your supervisor immediately after each medical appointment.** In order to return to your regularly assigned job, you are required to provide a physician's release stating the date you are able to return to full duty with no restrictions.

Employee signature:_____ Date:_____

cc: Payroll

GSA-EHS 02/13/13

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

Intercare
Holdings Insurance Services, Inc.

INTERCARE HOLDINGS
INSURANCE SERVICES INC
P.O. Box 579 Roseville, CA 95661
1 (800) 771-5454 FAX 1 (877) 362-5050

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

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.

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.

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 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.

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.*
    INTERCARE HOLDINGS INSURANCE SERVICES INC P.O. Box 579 Roseville, CA 95661
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.

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 día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

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.

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type if possible) Mail two copies to: Intercare Insurance Services — INTERCARE INSURANCE SERVICES, P.O. Box 1018 Sacramento, CA 95812-1018, 1 (800) 394-9304 FAX (916) 920-5588	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.
5. 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 DAY'S 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 (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/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 the, 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 WERE 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