CAL POLY
CORPORATION

Cal Poly Corporation

Workers' Compensation – Instruction Sheet

EMERGENCY and/or MEDICAL ATTENTION REQUESTED

[ ] Determine the extent of the injury/illness:

1. If this is a life-threatening emergency – call 9-1-1
   - call the CPC HR Office (756-1121) and let them know an employee has been injured and an ambulance is on the way (provide name and injury type)
2. For a serious injury/illness (or when Urgent Care is closed), take the employee to:

   Sierra Vista Hospital – ER
   1010 Murray Ave, SLO   Phone: 546-7650
   Open 24 hours

   - call the CPC HR Office (756-1121) and let them know you have taken an employee to the hospital (provide name and injury type)
3. If the injury/illness requires medical treatment, but is not life threatening, have the employee go to either:

   Family & Industrial Medical Center
   47 Santa Rosa St, SLO   Phone: 542-9596
   M-F: 8 am to 7 pm   **Sat/Sun: 9 am to 4 pm**

   Med Stop
   283 Madonna Rd, SLO   Phone: 549-8880
   M-F: 8 am to 7 pm   **Sat/Sun: 8 am to 4 pm**

4. If employee is unable to drive safely, have a FT CPC Manager or Supervisor take them to the medical facility
5. Give employee the DWC-1 Form and have them complete "Employee Section" (Lines 1-8); their Supervisor should complete the "Employer Section" (Lines 9-18)
6. Tear off the last 2 sheets of the packet and give to injured employee: 1) "Workers' Compensation Medical Care Authorization Form" – fill it out and have employee give it to the admission's clerk at the medical facility and tell them that the injury/illness is work-related **AND** clearly communicate that they work for Cal Poly **Corporation**; and 2) "Temporary Prescription Services" – have employee take it to a pharmacy if the doctor gives them a prescription

[ ] Complete Required Paperwork:

1. Complete Supervisor's Injury/Illness Report - fill out all sections, including specific details regarding injury (i.e., cut left middle finger with knife) – **FAX** to CPC HR Dept. that same day or the next work day! (805) 756-0181
2. **FAX** completed DWC-1 to CPC HR Dept. ASAP! (805) 756-0181
3. After medical care is received, forward the "Work Status Update" given to the employee by the Medical Facility (includes work restrictions and follow-up appointment information) to CPC HR

   Forward the fully-completed (and signed off) Original forms (Supervisor Report and DWC-1) to HR *(NOTE: give to Carole Demetri for CD; Lynnette Held for US)*
4. If employee has been placed off work, obtain a doctor's Work Release before allowing them to return to work; forward Release to CPC HR
5. **REMINDER:** employee must be paid for the entire shift they were scheduled to work on the day they were injured (punch edit if necessary)

NO Medical Attention Necessary or Requested

[ ] If employee does not need (or declines) medical treatment:

1. Treat with First Aid Kit, if necessary
2. Give employee the DWC-1 Form and have them complete "Employee Section" (Questions 1-8); their Supervisor should complete the "Employer Section" (Lines 9-18)
3. **In case the employee decides to seek treatment at a later date**, tear off the last 2 sheets of the packet and give to injured employee: 1) "Workers' Compensation Medical Care Authorization Form" - if they decide to seek treatment, have them give "Authorization" to the admission's clerk at the medical facility and tell them that the injury/illness is work-related; and 2) "Temporary Prescription Services" form – have employee take to the pharmacy if the doctor gives them a prescription

[ ] Complete Required Paperwork:

1. Complete Supervisor's Injury/Illness Report (fill out all sections, including specific details regarding injury i.e., cut left middle finger with knife) – **FAX** to CPC HR Dept. that same day or the next work day! (805) 756-0181
2. **FAX** completed DWC-1 to CPC HR Dept. ASAP! (805) 756-0181
3. If the employee decides to seek treatment at a later date, inform HR

   Forward the fully-completed (and signed off) Original forms (Supervisor Report and DWC-1) to CPC HR *(NOTE: give to Carole Demetri for CD; Lynnette Held for US)*

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SUPERVISOR'S INJURY/ILLNESS REPORT

(To be completed by the injured employee's supervisor for *any* work-related injury or illness)

DWC-1 FORM Given to Employee
(Must be given to employee within 24 hours)
Date: ______________________
By: ______________________

Date of Injury/Illness: ____________ **Time:** ________
Supervisor: ______________________
Department: ________________ **Ext:** ________
Injury Reported to: ______________________

COMPLETE REPORT AND SUBMIT TO THE CAL POLY CORPORATION HUMAN RESOURCES DEPT. (BLDG 15 RM 130) WITHIN 24 HOURS OF THE INJURY/ILLNESS OR AT THE BEGINNING OF THE FOLLOWING WORKDAY. ***PLEASE CALL 756-1151 FOR ALL SERIOUS INJURIES*** *OR FOR ASSISTANCE.*

INJURED EMPLOYEE INFORMATION

EMPLOYEE STATUS: ☐ **Regular (FT)** ☐ **Intermittent** ☐ **Student** ☐ **Additional Compensation**

Name: ______________________ **Date of Birth:** ________

Local Address: ______________________

Home Phone #: ____________ **Sex: M** ☐ **F** ☐ **Time: Shift Started** ______ **Scheduled Shift End:** ______

Job Title: ____________ **Avg. Weekly Hours:** ________ **Normal Work days:** ________

MEDICAL TREATMENT INFORMATION

Doctors on Duty (Santa Cruz) ☐

Was offsite Medical Treatment Necessary? Yes ☐ No ☐ Treated at: Family Ind. Med Ctr ☐ Sierra Vista ☐ Med Stop ☐

Onsite first aid administered? Yes ☐ No ☐ Treated By: ____________ Type of First Aid: ____________

Injured completed work shift? Yes ☐ No ☐ Comment: ______________________

NOTE: Make sure employee is paid for the entire shift they were scheduled to work on the day of injury

1. Where did the injury/illness occur? ______________________
2. What was the employee doing at the time of the injury/illness? ______________________
3. How did the injury/illness occur? ______________________
4. Witnesses (names and phone #s) ______________________
5. a. Describe the injury or illness ______________________

   b. Part of body affected (be specific) ______________________
6. What was the cause of the injury/illness? ______________________
7. a. What steps are necessary to prevent recurrence of a similar injury/illness? ______________________

   b. Have you taken these steps? Yes ☐ No ☐ Explain ______________________

Supervisor's Signature	Date	Department Head's Signature	Date

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.* Cal Poly Corporation
10. Address. *Dirección.* 1 Grand Ave, Bld 15 - San Luis Obispo, CA 93407
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.* Sedgwick CMS P.O. Box 14629 Lexington, KY 40512
15. Insurance Policy Number. *El número de la póliza de Seguro.* Self-Insured
16. Signature of employer representative. *Firma del representante del empleador.* ______
17. Title. *Título.* ______ 18. Telephone. *Teléfono.* (805) 756-1151

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.

EMPLOYEE: give this form to the admission's clerk at the Urgent Care Center or Hospital at check in

CAL POLY
CORPORATION

CAL POLY CORPORATION
WORKERS' COMPENSATION
MEDICAL CARE AUTHORIZATION FORM

EMPLOYEE'S NAME: ____

SOCIAL SECURITY #: _____ - _____ - _____ **DATE OF INJURY:** ____________________

PREFERRED PROVIDERS: (check one)

1. If the injury/illness requires medical treatment, but is not life threatening – go to either:

☐ **FAMILY & INDUSTRIAL MEDICAL CENTER** - 47 Santa Rosa St ,SLO **Ph: 542-9596**

Hours:	M-F	8 am to 7 pm
	Sat-Sun	9 am to 4 pm

or

☐ **MED STOP** – 283 Madonna Rd, SLO **Ph: 549-8880**

Hours:	M-F	8 am to 7 pm
	Sat-Sun	8 am to 4 pm

2. If the injury/illness is serious, life threatening, or FIMC and Med Stop are closed – go to:

☐ **SIERRA VISTA HOSPITAL ER** - 1010 Murray Ave, SLO **Ph: 546-7650**

Hours:	M-Sun	open 24 hours

PREFERRED PROVIDER - Immediately **FAX** Doctor's First Report of Work Injury to:

Sedgwick CMS - **FAX: (916) 851-8079**
P.O. Box 14629
Lexington, KY 40512
Phone: (916) 636-4451

and

Cal Poly Corporation – Human Resources Department **– FAX: (805) 756-0181**
1 Grand Ave, Building 15
San Luis Obispo, CA 93407
Phone: (805) 756-6434

NOTICE TO THE EMPLOYEE: Your employer has recommended a local Urgent Care network of physicians to treat your injury or illness. If you wish to change doctors, you may do so 30 days after Report of Injury. If treatment continues for more than 30 after you claim a work-related injury or illness, you have the right to choose your own physician after informing Cal Poly Corporation HR. You are also entitled to be treated by your own personal physician if you have notified your employer in writing before the injury.

EXPRESS SCRIPTS®

Workers' Compensation

INJURED EMPLOYEE:

If an ER or Urgent Care physician gives you a prescription to be filled for your work-related injury, give the pharmacy this form so the prescription charge(s) will be paid by Workers' Compensation.

Temporary Prescription Services

Attention Injured Worker

- On your first visit, please give this notice to any pharmacy listed below to expedite the processing of your approved workers' compensation prescriptions. (Based on the established parameters by your employer.)
- Questions or Need Assistance Locating a Participating Pharmacy: Call the Express Scripts Contact Center at 888.786.9640.

Attention Supervisor: Please complete the following information for the injured worker

Express Scripts

ID #: SSN to be presented to the pharmacy at the time prescription is filled

Date of Injury: MM/DD/CCYY

Group #: GJC29573

Employee Date of Birth: MM/DD/CCYY

Employee Information

Employee Name

Mailing Address

Street Address or PO Box

City State Zip

Employer's Name: Cal Poly Corporation
1 Grand Ave, Bld 15
San Luis Obispo, CA 93407

Attention Pharmacist

- Express Scripts administers this workers' compensation prescription program. **Follow the steps below to submit a claim.**
- For assistance, call the Express Scripts Contact Center at 888.786.9640.

Pharmacy Processing Steps	
Step 1	Enter bin number 003858
Step 2	Enter processor control A4
Step 3	Enter the group number as it appears above
Step 4	Enter the injured worker's 9 digit ID#
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of injury (enter in PA field in the format ccyymmdd)

Participating Pharmacy Chains

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
AmerisourceBergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Cobom's
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's

Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Duane Reade
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Shop 'N Save
Shopko
ShopRite
Snyder
Star Markets
Stop & Shop
Sun Mart
Super Fresh
Target

Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Happy Harry's
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Texas Oncology Services
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets

Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie