

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

1. If employee is unable to drive safely, have a FT CPC Manager or Supervisor take them to the medical facility
2. 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)
3. 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
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:**

4. Treat with First Aid Kit, if necessary
5. 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)
6. **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**
4. Forward the fully-completed (and signed off) Original forms (Supervisor Report and DWC-1) to CPC HR

Questions? Contact:

Jill Connelly, HR Manager
 jskonnel@calpoly.edu, 6-5580
 Nancy Mora, HR Coordinator
 namora@calpoly.edu, 6-6434

CAL POLY CORPORATION
SUPERVISOR'S INJURY/ILLNESS REPORT



CAL POLY
 Corporation

(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 756-5580 FOR ALL SERIOUS INJURIES OR FOR ASSISTANCE.

INJURED EMPLOYEE INFORMATION

EMPLOYEE STATUS: Regular (FT) Intermittent Student Additional Compensation

Name _____ Date of Birth _____

Local Address _____

Cell Phone # _____ Sex M F Time Shift Started: _____ Scheduled Shift End: _____

Job Title _____ Avg. Weekly Hours _____ Work days M T W TH F S S

MEDICAL TREATMENT INFORMATION

Doctors on Duty (Santa Cruz)

Was offsite medical treatment necessary? Yes No If yes, treatment 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



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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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 gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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 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. Check if you agree to receive notices about your claim by email only. *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.

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

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.



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.

Atencion Trabajador Lesionado:

- Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).
- Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 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:

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 ccyyymmdd)

Participating Pharmacy Chains

A & P	Costco	Fred's	Medicap
Acme Pharmacy	Cub	Gemmel	Medistat
Albertson's	CVS	Giant	Meijer
Albertson's/Acme	D&W	Giant Eagle	Minyard
Albertson's/Osco	Dahl's	Giant Foods	NCS HealthCare
Albertson's/Sav-On	Dierbergs	Hannaford	Neighborcare
AmerisourceBergen	Discount Drugmart	Happy Harry's	Network Pharmaceuticals
Anchor Pharmacies	Doc's Drugs	Harris Teeter	Northeast Pharmacy Services
Arrow	Dominicks	H-E-B	Osco
Aurora	Drug Emporium	Hi-School Pharmacy	P & C Food Markets
Bartell Drugs	Drug Fair	Hy-Vee	Pamida
Bigg's	Drug Town	Jewel/Osco	Park Nicollet
Bi-Lo	Drug World	Kash n Karry	Pathmark
Bi-Mart	Duane Reade	Keltsch	Pavilions
BJ's Wholesale Club	Eckerd	Kerr	Price Chopper
Brooks	Econofoods	Kmart	Publix
Brookshire Brothers	EPIC Pharmacy Network	Knight Drugs	Quality Markets
Brookshire Grocery	FamilyMeds	LeaderNet (PSAO)	Raley's
Bruno	Farm Fresh	Longs Drug Store	Randalls
Carrs	Farmer Jack	Major Value	Rite Aid
Cash Wise	Food City	Marsh Drugs	Rosauers
Coborn's	Food Lion	Medic Discount	Rx Express

RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's

Shop 'N Save
Shopko
ShopRite
Snyder
Star Markets
Stop & Shop
Sun Mart
Super Fresh
Target

Texas Oncology Services
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets

Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie