THE SUPERVISOR'S ROLE:

Workers' Compensation Information for CSU, Los Angeles Supervisors



Human Resources Management (HRM)

Workers' Compensation Program

February 2019

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Introduction

As a manager/supervisor or lead, you need to be familiar with workers' compensation and how it applies to your employees. This booklet provides you with a summary of the Workers' Compensation Program and outlines your responsibilities in the event that one of your employees has an on-the-job injury.

Workers' Compensation Definitions

Workers' Compensation

The workers' compensation system was established to provide benefits to employees who sustain a work-related injury or illness. Benefits include medical treatment costs, temporary disability payments for lost wages, permanent disability payments for a decreased ability to compete in the open labor market, and death benefits to an employee's dependent(s). Under workers' compensation law, an employee receives benefits if he or she is injured no matter who is at fault.

Work-Related Injury

Throughout this booklet, the term "work-related injury" will be used to describe any injury or illness that occurs during the course of employment and results from work or working conditions.

Example of an injury: An employee sprains his or her back while lifting a heavy box at work.

Example of an illness: An employee gets a skin rash as a result of exposure to chemicals or solvents used at the work site.

Sedgwick,CMS

Sedgwick, CMS administers workers' compensation claims on behalf of the CSU. Sedgwick, CMS makes all liability determinations and ensures an injured worker receives the benefits to which he or she is entitled.

Workers' Compensation/Disability Management Coordinator (WC/DMC)

Each campus has someone designated as the Workers' Compensation/Disability Management Coordinator. This person is responsible for managing the workers' compensation cases for the campus. This person is responsible for advising supervisors and employees on the workers' compensation process and the benefits to which an injured employee may be entitled. The WC/DMC can assist you in dealing with questions regarding an employee's claim for workers' compensation.

The Workers' Compensation/Disability Management Coordinator is responsible for assisting injured employees in returning to work as soon as medically feasible. The WC/DMC will rely on you to provide him or her with updated medical slips, information on the availability of transitional duty (e.g., light duty), or the ability to temporarily modify the employee's usual and customary job.

Your Responsibilities

Before An Injury Occurs

The law requires each employer to provide a safe place of employment. The University is required to have a comprehensive Injury and Illness Prevention Program (IIPP). The IIPP focuses on preventing the types of injuries and illnesses most common in your work environment. You are required to know the elements of the University's IIPP and train your employees on various policies and procedures to be followed. Contact the Environmental Health and Safety Office to obtain a copy of the IIPP or check the RM/EHS website (http://www.calstatela.edu/MSDS).

Despite efforts to prevent injuries, they still occur. Therefore, you need to instruct your employees to report any and all incidents of work-related injury/illness on the same day of the incident.

A work-related injury or illness can occur when it is least expected. Knowing what to do when an injury occurs gives your employees assurance that they will be cared for properly.

After An Injury Occurs

In the event of an on-the-job injury, supervisors must ensure employees receive prompt and proper medical care, if such care is believed necessary by either the supervisor or the employee.

For injuries requiring immediate emergency assistance, dial 911. The Student Health Center or Concentra is the university designated providers. You or someone you designate is responsible for accompanying the injured employee to the doctor.

While at the doctor's office, find out from the doctor if the injured employee will be able to return to work. If the employee is not able to return to work immediately, find out how long the employee will be off work. Your description of the employee's normal duties, or of alternate "light duty" work that may be available, may help the doctor make a decision. In this way, you may save the employee lost time from work and assist in conserving sick leave or other leave credits.

Reporting the Injury

Within one working day of knowing there's been an injury or illness, you must complete the Supervisor's Report of Injury/Illness form and submit to HRM.

As a supervisor or manager, you must also have the employee complete the *Employee's Report of Occupational Injury or Illness* form. Once you have received the completed form, forward it to your department's designated Unit. Your department must provide this completed form to HRM within one working day of knowledge that a work-related injury has occurred. Late reporting could cause a delay in the employee receiving benefits.

Once the injury has been reported and it is determined to be more than first aid, Sedgwick will contact the supervisor to verify the claim and obtain further information regarding the incident.

Maintaining Contact with Your Injured Employee

One of the most important responsibilities of a supervisor is to maintain contact with any employee who is injured on the job. Your support and encouragement during the period of disability will help the employee feel connected to the workplace and will contribute to the employee's desire to return to work as soon as it is medically feasible.

When to Call: Monthly, or more often if important information needs to be passed on. If possible, calls should be made during regular work hours.

What to Discuss: The purpose of regular contact is to show concern and support for the injured/ill employee, and to help answer any questions they may have. Typical remarks/questions may include:

- "How are you doing?"
- "Do you have any questions or concerns? I'll help if I can, or if not, I'll put you in touch with someone who can."

When Not to Call: Sometimes it is not helpful to call an injured/ill employee. Inappropriate circumstances might include the following:

- The employee specifically asks you not to call any more.
- The employee seems to be angered by your calls.
- You have a history of conflict with this employee and believe they may view your calls as a form of harassment.

What Not to Discuss: The goal of contact is not to interrogate the employee, investigate their injury, or do anything that can be interpreted negatively. Therefore, remember:

- Do not ask questions directly or indirectly designed to "check up on" the employee or to "catch them in a lie." If the employee's injury seems suspect to you, let the Workers' Compensation Unit deal with that issue.
- Do not ask for medical information such as diagnoses, treatment, or prognosis.

Absence Reporting

All time off due to the injury or illness must be reported on the Absence Request form (STD 634). No time is charged against leave credits on the day the injury or illness occurred. Employees who are absent less than three days are charged leave credits for the time off.

Notify the Workers' Compensation Unit promptly when the employee returns to work. The employee must provide a copy of the written release to you and the original to the Workers' Compensation Unit in order to return to work from the treating physician **before** he or she is allowed to resume his or her duties.

Employee Responsibilities

Under the general direction of the manager/supervisor employees will:

Participate in achieving safety goals.

Attend safety training provided by the department.

Understand and comply with all safety rules and regulations.

Report all injuries and accidents to the supervisor immediately.

Complete employee's report of injury/illness form.

Perform all activities using the proper tools, personal protective equipment and safety devices.

Recognize potential safety hazards and report them to the supervisor.

Suggest possible safety hazard corrections.

Keep supervisors informed of any limitations that interfere with safe performance of assigned work.

Maintain contact with your supervisor if you are off work due to an injury by providing current work status slips.

Cooperate with the doctor and other medical providers (e.g. physical therapist), Workers' Compensation Coordinator, and supervisor in returning to work as soon as medically feasible.

Workers' Compensation Benefits

Medical Care

An injured worker will receive all the medical care reasonably required to cure or relieve the effects of the work-related injury.

For the first 30 days following the date the injury was reported, the University-designated physician should treat the injured worker. After the initial 30-day period, the employee may choose to receive medical care from another primary treating physician. However, an employee has the right to seek treatment from a predesignated personal physician or personal chiropractor. The predesignated personal physician or chiropractor must have treated the employee and maintain his or her medical or chiropractic records. The employee would have had to designate this physician or chiropractor, in writing, prior to the injury or illness.

Temporary Disability Benefits

The state offers various types of temporary disability benefit programs under workers' compensation: Temporary Disability, Industrial Disability Leave, with or without supplementation.

Before benefits start, most disabled employees will serve a waiting period of three calendar days. The waiting period need not be consecutive days. The waiting period is waived if the employee is hospitalized, if the injury was caused by a criminal act of violence, if the employee is disabled more than 14 calendar days.

TEMPORARY DISABILITY (TD) payments start on the fourth day of approved absence from work due to a work-related injury. TD is based on two-thirds of gross pay at the time of injury. The law allows state employees to supplement TD payments with accrued leave credits up to the amount of their full pay.

INDUSTRIAL DISABILITY LEAVE (IDL) payments are available only to active members of the California Public Employees' Retirement System (CalPERS) or the California State Teachers' Retirement System (Cal STRS). This benefit is a salary continuation program that is significantly better than the standard TD benefit. IDL is available to employees for 52 weeks within a two-year period from the first day of disability. IDL payments are based on the employee's full net pay for the first 22 working days of disability and after that are calculated at two-thirds of the employee's gross pay. Employees can supplement IDL payments with accrued leave credits up to the amount of their approximate full net pay.

The Human Resources Management Office will provide detailed benefit information to the injured employee.

Permanent Disability Benefits

A qualified medical examiner will write a "permanent and stationary" report when the condition of an injured employee has stabilized and is not expected to get better or worse. The report will describe the lasting effect, if any, of the injury or illness. Permanent Disability (PD) is the term used to describe any lasting effects of the industrial injury. Benefits are set by law and are not reduced by other income, even if the injured employee returns to work. PD payments may not be supplemented with leave credits.

The Disability Evaluation Unit of the Division of Workers' Compensation will determine the amount of any permanent disability rating.

Contacts

Workers' Compensation/Disability Management Coordinator:

Denise Watson-Cross

Phone: (323) 343-3657

Sedgwick, CMS:

Phone: (916) 852-2946

Campus Medical Providers:

Student Health Center:

Phone: (323) 343-3301

Concentra

Phone: (626) 407-0300 El Monte facility

(323) 722-8481 Commerce facility

Human Resources Management

SUPERVISOR'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

California law requires an employer to report within five days every injury or occupational illness which: (1) results in time lost beyond the day of injury or (2) requires medical treatment other than first aid.

This report is required by our TPA and the Department of Industrial Relations. Send **ONE COPY** to Human Resources Management (HRM), Attn: Workers' Compensation Coordinator, Adm. 606 (Mail Code 8534-01). HRM will prepare and submit the official report to the TPA. Make and retain a copy of the report for your file. **FATAL** or **SERIOUS** injuries/illnesses must be reported **IMMEDIATELY** by telephone and on this form to Human Resources Management, which will then report to the TPA and the Division of Industrial Safety as required by law. The Department of Public Safety is responsible for making these reports to the Division of Industrial Safety when Human Resources Management is closed.

If you have any questions, please call extension 3657.

PLEASE REPORT ALL INJURIES (no matter how trivial) WITHIN ONE WORKING DAY TO YOUR EMPLOYER.
FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

Part A - PERSONAL INFORMATION

Name of injured:_____ Social Security Number :_____

Home Address (Number and Street, City Zip):_____

Home Phone Number: _____Birth Date:_____

Part B – EMPLOYMENT STATUS

Classification:_____ Department :_____

Supervisor_____ Hire Date _____

Status: _____ Full-Time _____ Part-Time

Salary: $ _____per month or $ _____per hour. Hours Worked: _____Daily _____Weekly

Part C - INJURY/ILLNESS

Date _____Time: _____a.m./p.m. Date Employee Reported Injury:_____

Witnesses (Names and Telephone Numbers):

1 _____ 3 _____

2 _____ 4 _____

Where did injury/illness occur?_____

What was the employee doing when injured?_____

How did the injury/illness occur?_____

Describe the nature of the injury/illness. _____

(Over)

PLEASE ANSWER ALL QUESTIONS

Part - C (*Continued*)

Describe the part(s) of the body injured. _____

Was another person responsible?_____ Yes:_____ No: If yes, explain._____

Part D - MEDICAL TREATMENT

Where did you receive treatment?

_____CSULA Student Health Center

_____Concentra Medical Group

_____Hospital: Name_____

Address_____

_____Other: Name_____

_____Declined Medical Care

Part E - RETURN TO WORK

Did you lose at least one (1) full day of work after the date of injury/illness? _____Yes _____No

Did you return to work? Yes (returned to work on_____) _____No

What type of work did you return to: _____ Regular _____ Modified

If you were unable to perform full duty, what type of temporary-modified work was made available to you? _____

_____

My supervisor arranged temporary-modified work for_____ day(s) beginning on _____

Part F - ACCIDENT PREVENTION

Describe the workplace and conditions that may have contributed to the injury/illness and safety devices present:_____

_____

_____

What recommendations would you suggest that may correct the condition(s) and/or prevents future injuries/illnesses of this type?

_____

_____

_____

_____

Supervisor Signature: _____ Date: _____

Position Title: _____ Extension: _____

HRM USE ONLY

Position Number: _____Salary: $ _____ Hire Date: _____

_____

_____***HRM/EEREPT (REV 02/19)***

Human Resources Management

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. Notify your immediate supervisor as soon as possible of any injury/illness sustained during the course of your work with Cal State L.A.

2. Obtain medical care from
   - Cal State L.A. Student Health Center or
   - Concentra Group or
   - Your personal physician (authorized only if you have submitted a Designation of Physician form to Human Resources Management Before your Date of Injury).

3. Within one working day, complete and return to your immediate supervisor:
   - Employee's Report of Occupational Injury/Illness

4. Continue with medical treatment as prescribed by the treating medical provider. After each medical visit, submit a copy of your medical status documents to:
   - Your immediate supervisor, and
   - Human Resources Management

Upon receipt of the appropriate forms, Human Resources Management will coordinate the claim processing with the University's insurance provider, the employing department, the medical provider and the employee. Should you require further assistance with this form, please contact your Workers' Compensation Coordinator at extension 3657.

Part A - PERSONAL INFORMATION

Name of injured:_____ Social Security Number: _____

Home Address (Number and Street, City, Zip):_____

Home Phone Number: _____ Birth Date: _____

Part B – EMPLOYMENT STATUS

Classification:_____ Department: _____

Supervisor:_____ Hire Date :_____

Part C - INJURY/ILLNESS

Date :_____Time: _____a.m./p.m. Date Employee Reported Injury:_____

Witnesses (Names and Telephone Numbers):

1 _____ 3 _____

2 _____ 4 _____

Where did injury/illness occur?_____

What were you doing when the injury/illness occurred?_____

How did the injury/illness occur?_____

_____

_____

Describe the nature of the injury/illness. _____

PLEASE ANSWER ALL QUESTIONS

Part - C (*Continued*)

Describe the part(s) of the body injured. _____

Was another person responsible? _____Yes: _____ No: If yes explain._____

_____

Part D - MEDICAL TREATMENT

Where did you receive treatment:

_____CSULA Student Health Center

_____Concentra Medical Group

_____Hospital: Name _____

Address _____

_____Other: Name _____

_____Declined Medical Care

_____

Part E - RETURN TO WORK

Did you lose at least one (1) full day of work after the date of injury/illness? _____Yes _____No

Did you return to work? Yes (returned to work on_____) _____No

What type of work did you return to: _____ Regular _____ Modified

If you were unable to perform full duty, what type of temporary-modified work was made available to you? _____
_____

My supervisor arranged temporary-modified work for_____ day(s) beginning on _____
_____

Part F - ACCIDENT PREVENTION

Describe the workplace and conditions that may have contributed to the injury/illness and safety devices present: _____
_____

_____

What recommendations would you suggest that may correct the condition(s) and/or prevent future injuries/illnesses of this type?
_____

_____

_____

Additional Comments: _____

_____

Employee's Signature: _____ Date: _____

Position Title: _____ Extension: _____

HRM USE ONLY

Position Number: _____Salary: $ _____ Hire Date: _____

HRM/EEREPT (REV 02/19)

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 trabjador.*

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.

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*

7/1/04 Rev.