HUMAN RESOURCES DEVELOPMENT
AND PERSONNEL SERVICES

TO: All Staff

FROM: Jacques S. Whitfield, Director of Human Resources Development and Personnel Services

RE: Work Related Incident/Accident

Employees are responsible to report incidents/accidents immediately to their Supervisor. All occupational incidents, accidents or exposures to hazardous substances must be reported to the Office of Human Resources within twenty-four (24) hours after the incident becomes known to the Supervisor. For those incidents/accidents that require hospitalization for a period in excess of twenty-four (24) hours, the HRD/PS office will contact Cal/OSHA within eight (8) hours. If after hours and the Supervisor is not available, report the incident/accident to the YCCD Police Department.

These guidelines have been developed to assist the employee in reporting a work related incident or accident.

Work Related Incidents/Accidents

1. The employee must report the accident to his/her immediate supervisor and complete an Employee Report of Work Related Incident/Accident form. The supervisor must complete the Incident/Accident Report form. If the injury *does not* qualify as a "First Aid Claim" as defined in 8 CCR 14311 (to be determined by a medical facility Physician), and the employee has sought medical treatment, the employee will need to complete a Workers' Compensation Claim Form DWC 1. All forms are available from the Vice Chancellor's office or the main office at each YCCD site.

2. If medical treatment is necessary, please see the list of treatment locations on the reverse side of this memo. If the employee chooses to use a physician or a facility other than those on this list, the employee is responsible for the cost of all visits.

3. The District has the responsibility to provide forms to the employee within twenty-four (24) hours of knowledge of a work-related incident/accident and file the claim online with the District's insurance carrier *within three (3) days.*

Medical Treatment Necessary

The medical doctor will provide a Work Activity Status Report to the employee. This report will generally list three options:

a. Employee returns to work <u>without</u> limitations (released from care).
b. Employee returns to work <u>with</u> limitations (modified activity).
c. Employee cannot return to work unless released by the medical Doctor (no activity).

It is the employee's responsibility to provide the medical Work Activity Status Report to the supervisor *and* Office of Human Resources.

Follow-up

1. The Office of Human Resources will complete the necessary State forms and submit them to the District insurance carrier, Keenan and Associates.
2. The insurance carrier may need to complete a work site visit to assist the employee in performing the basic functions of his/her job.
3. If a work site visit is necessary, a representative from the insurance carrier will verbally inform the employee and supervisor of the findings and recommendations during the site visit. A written report is submitted to the Office of Human Resources.

Information for employees needing medical treatment for a work-related incident/accident:

YUBA COLLEGE AND BEALE AFB OUTREACH OPERATION

Fremont-Rideout Occupational Health & Drug Testing Services
1531 Plumas Court
Yuba City, CA 95991
(530) 751-4900

CLEAR LAKE CAMPUS

Sutter Lakeside Hospital
5176 Hill Road
Lakeport, CA 95453
(707) 262-5000

Redbud Hospital
18th Avenue and Highway
Clearlake, CA 95422
(707) 994-8138

COLUSA COUNTY FACILITY

Colusa Community Hospital
199 East Webster Street
Colusa, CA 95932
(530) 458-5821

WOODLAND COMMUNITY COLLEGE

Woodland Healthcare-Woodland Clinic
632 W. Gibson Road
Woodland, CA 95695-4398
(530) 668-2660

Woodland Healthcare - Davis
2330 W. Covell Blvd.
Davis, CA 95616
(530) 406-2885

WORKERS' COMPENSATION INSURANCE CARRIER

Keenan and Associates
P.O. Box 1538
Rancho Cordova, CA 95741
1 800 343-0694

YUBA COMMUNITY COLLEGE DISTRICT

Maribel Gaytan
Personnel Analyst
Office of Human Resources
2088 North Beale Road
Marysville, CA 95901
(530) 741-6975

If the employee chooses to see a physician or a facility other than those on this list, the employee is responsible for the cost of all visits. Please provide the physician's name to YCCD and also request that the Physician send YCCD a copy of the Doctors' Report.

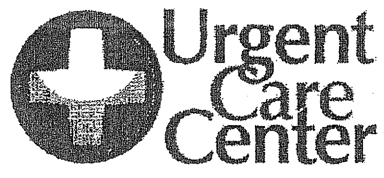
11/12

HK

In Case of Work Injury

- Immediately report your injury to your employer
- Obtain a treatment authorization slip
- Go directly to Fremont-Rideout Occupational Health

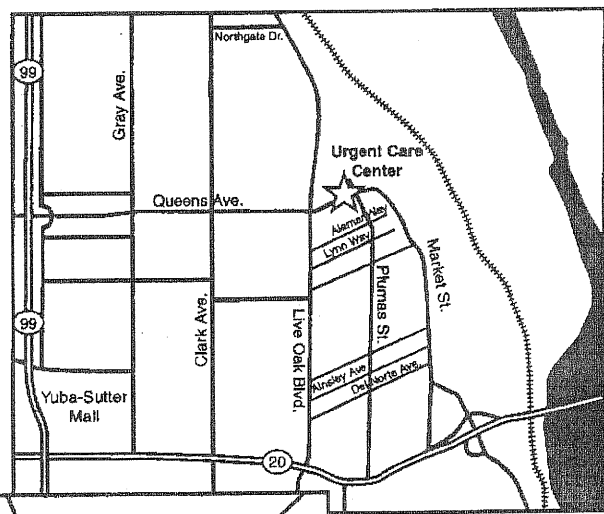
Location: 1531 Plumas Court, Yuba City

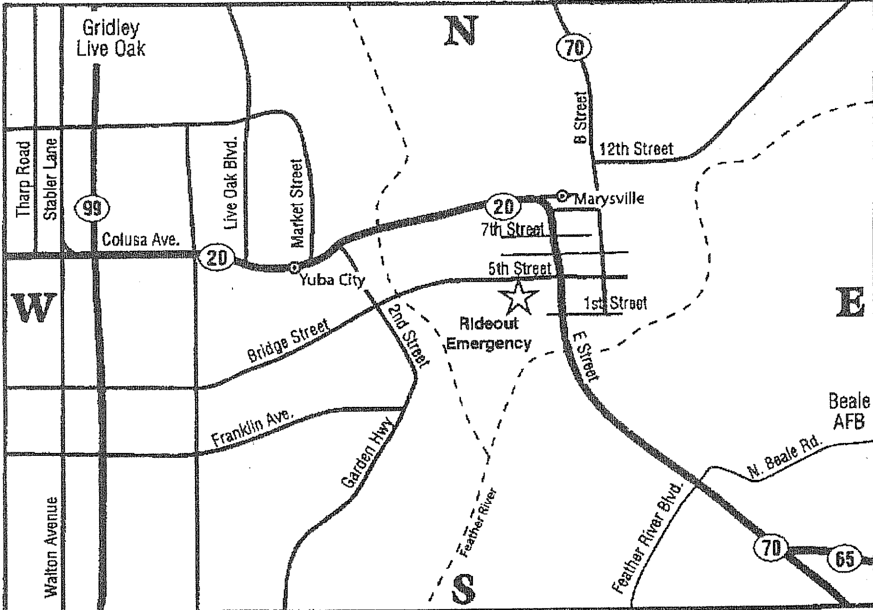


(530) 751-4900

Monday-Friday
7am-7pm

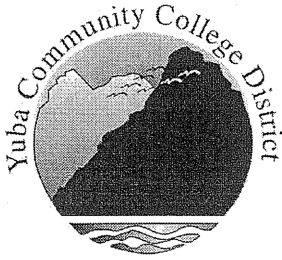
Saturday-Sunday
& Holidays
10am-6pm





After Hours:
Rideout
Emergency
Corner of 3rd
and G Streets,
Marysville

OH005-0509



MEMORANDUM

Date:

To:

From: Maribel Y. Gaytan, Personnel Analyst

Re: Workers' Compensation

Attached is the necessary documentation to submit a Workers' Compensation claim. If you would like to complete the attached packet and file a claim, please indicate below:

_________ Yes, I will complete the Workers' Compensation packet.

_________ No, I decline to complete the paperwork and do not wish to pursue Workers' Comp. benefits. **Please return packet with this form to Maribel Gaytan, Personnel Analyst, YCCD, Human Resources Development and Personnel Services, Room 21, Marysville, CA 95901.**

If you have any questions, please contact our office at (530) 741-6975

_______________________________ _______________

Employee/Student Signature Date

YUBA COMMUNITY COLLEGE DISTRICT WORK-RELATED INCIDENT/ACCIDENT REPORT

TO BE COMPLETED BY THE

EMPLOYEE

DID (OR DOES) YOUR INJURY REQUIRE MEDICAL TREATMENT? YES NO

DID (OR DOES) YOUR INJURY REQUIRE LOSS OF TIME AT WORK? YES NO

EMPLOYEE NAME: ______________________ SOCIAL SECURITY #: __________ DATE OF BIRTH: ________

FIRST LAST MIDDLE

HOME ADDRESS: ____

STREET CITY STATE ZIP

TELEPHONE NUMBER: ________ SEX: MALE FEMALE

OCCUPATION: ______________________ HIRE DATE: ________ WAGE - $ ________ PER

PAY STATUS: REG. FULL-TIME PART-TIME STUDENT STUDENT/VOC. TECH.

7-Date of Accident/Incident: ______________________ 8-TIME ________ am pm

MONTH DAY YEAR

9-Time you began work: ________ am ________ pm

11-Were you unable to work for at least one full day after date of accident? YES NO

12-If unable to work, date last worked: ____________ 13-Date returned to work: ________

14-Are you still off work? YES NO

17-Date you first notified employer of accident: ______________

18-Date employer provided employee claim form: ______________

19-Specific accident/incident (describe parts of body affected/medical diagnosis):

20-Address where event or exposure occurred: ______________________

21-On Employers Premises? YES NO

22-Department where event or exposure occurred: ______________________

23-Were others injured? (if so, please state name): ______________________

24-Equipment, materials, chemicals you were using at time of the event or exposure:

25-Specific activity you were performing when event or exposure occurred:

26-How accident/incident occurred; describe sequence of events:

27-Name and address of Physician: ______________________

28-Hospitalized as an Inpatient Overnight? YES NO

29-Treated in the emergency room? YES NO

If yes, Name of Hospital ______________________

Report Completed by: ______________________

Employee Signature

Report Completed on: ____________ ____________

Date Time

Report Received by: ______________________ Date: ____________

YUBA COMMUNITY COLLEGE DISTRICT INCIDENT/ACCIDENT INVESTIGATION REPORT

TO BE COMPLETED BY THE

SUPERVISOR

NAME OF INJURED: ______________________________

LAST FIRST MIDDLE

ADDRESS: ______________________________ TELEPHONE ____________

STREET CITY STATE ZIP

JOB TITLE: ______________________ SEX ________ DATE OF BIRTH ____________

INSTRUCTOR/SUPERVISOR NAME: ______________________

PERSON INVOLVED IS: STUDENT ________ STAFF ________ VISITOR ________ OTHER ________

DATE OF INCIDENT/ACCIDENT: ____________ HOUR ________ PHOTOS YES / NO (Circle One)

DATE REPORTED: ____________ HOUR ________

INCIDENT/ACCIDENT LOCATION: ______________________

WITNESSES: NAMES, ADDRESSES, TELEPHONE NUMBERS:

1 ______________________________

2 ______________________________

TIME NOTIFIED: ________ AM / PM (Circle One) TIME ON SCENE ________ AM / PM (Circle One) TIME OFF SCENE AM / PM (Circle One)

FIELD INVESTIGATION

Exact Location of Incident/Accident:

Describe in detail the l**ocation of incident**: including lighting, walking surface, weather, measurements, and any other condition that could have contributed to or prevented the incident:

Describe **the incident/accident which you observed** or which were described to you:

Describe **demeanor of person involved** and include statements made:

Describe **shoes, physical appearance and any other characteristic** that would contribute to understanding how the incident/accident occurred:

Describe **how the incident/accident occurred**; state facts, contributing factors, cite witnesses and support evidence:

Steps/Corrective Action taken:

Does the employee's incident/accident require medical care? (Check one) Yes ________ No ________

If yes, name of Medical Facility and Doctor (state Work Comp Clinic if filing a claim):

Supervisor's Signature

(Print) Supervisor's Name

Telephone Number

Report Completed On: ________ Date ________ Time

Original: Director of HRD/PS
Building 100A, Room 21