



Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering.
- **Permanent Disability (PD) Benefits:** Payments if your injury causes a permanent disability.
- **Vocational Rehabilitation:** Services and payments if your injury prevents you from returning to your usual job or occupation. This benefit applies to injuries that occurred prior to 1/1/04.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

Naming Your Own Physician Before Injury. You may be able to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury. If eligible, you must tell your employer, in writing, the name and address of your personal physician *before* you are injured. For instructions, see the written information about workers' compensation that your employer is now required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need first aid, contact your employer. If you need emergency care, call for help immediately. Emergency phone numbers:

Ambulance _____ Fire Dept. _____ Police _____
Doctor _____ Hospital _____

2. **Report Your Injury.** Report the injury immediately to your supervisor or to:
Employer representative _____ phone number _____.

Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you named your personal physician before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator GuideOne Insurance

Address PMB 305, 2351 Sunset Blvd., Ste 170 City Rocklin State CA Zip 95765

Phone 800-647-9324 Policy Expiration Date _____

The employer is insured for workers' compensation by GuideOne Mutual Insurance Co.
1111 Ashworth Rd., West Des Moines IA 50265
(Enter "self-insured" if appropriate)

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement - their number can be found in your local White Pages under California State Government, Department of Industrial Relations.

You can get free information from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer is at:

Address _____ City _____ Phone _____

Hear recorded information and a list of local offices by calling toll-free (800) 736-7401. Learn more online: www.dir.ca.gov.

False claims and false denials. 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

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.

E M P L O Y E R	1. FIRM NAME	1a. Policy Number	Please do not use this Column
	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	OWNERSHIP
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.	5. State unemployment insurance acct. no.	INDUSTRY
6. TYPE OF EMPLOYER <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____			

I N J U R Y O R I L L N E S S	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)	OCCUPATION	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes	12. DATE LAST WORKED (mm / dd / yy)	13. DATE RETURNED TO WORK (mm / dd / yy)	14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		
	15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm / dd / yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy)	SEX	
	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				AGE	
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop		23. Other Workers Injured/Ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No			DAYS PER WEEK
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold:					WEEKLY HOURS
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck					WEEKLY WAGE
	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.					COUNTY
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)			27a. Phone Number	NATURE OF INJURY	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)			28a. Phone Number	PART OF BODY		
			29. Employee treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> 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.*

E M P L O Y E E	30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm / dd / yy)	EVENT	
	33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER		SECONDARY SOURCE	
	34. SEX <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		EXTENT OF INJURY	

Completed By (type or print)	Signature & Title	Date (mm / dd / yy)
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*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.

WHISTLEBLOWERS ARE PROTECTED

It is the public policy of the State of California to encourage employees to notify an appropriate government or law enforcement agency when they have reason to believe their employer is violating a state or federal statute, or violating or not complying with a state or federal rule or regulation.

Who is protected?

Pursuant to California Labor Code Section 1102.5, employees are the protected class of individuals. "Employee" means any person employed by an employer, private or public, including, but not limited to, individuals employed by the state or any subdivision thereof, any county, city, city and county, including any charter city or county, and any school district, community college district, municipal or public corporation, political subdivision, or the University of California. [California Labor Code Section 1106]

What is a whistleblower?

A "whistleblower" is an employee who discloses information to a government or law enforcement agency where the employee has reasonable cause to believe that the information discloses:

1. A violation of a state or federal statute,
2. A violation or noncompliance with a state or federal rule or regulation, or
3. With reference to employee safety or health, unsafe working conditions or work practices in the employee's employment or place of employment.

What protections are afforded to whistleblowers?

1. An employer may not make, adopt, or enforce any rule, regulation, or policy preventing an employee from being a whistleblower.
2. An employer may not retaliate against an employee who is a whistleblower.
3. An employer may not retaliate against an employee for refusing to participate in an activity that would result in a violation of a state or federal statute, or a violation or noncompliance with a state or federal rule or regulation.
4. An employer may not retaliate against an employee for having exercised his or her rights as a whistleblower in any former employment.

Under California Labor Code Section 98.6, if an employer retaliates against a whistleblower, the employer may be required to reinstate the employee's employment and work benefits, pay lost wages, and take other steps necessary to comply with the law.

How to report improper acts

If you have information regarding possible violations of state or federal statutes, rules, or regulations, or violations of fiduciary responsibility by a corporation or limited liability company to its shareholders, investors, or employees, **call the California State Attorney General's Whistleblower Hotline at 1-800-952-5225**. The Attorney General will refer your call to the appropriate government authority for review and possible investigation.