NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with:

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON  NUMERO DE POLIZA 09616923V

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Titulo 23, Capítulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensación por medio de:

Además, a todos los empleados se les notifica por este medio que en caso de que específicamente ellos no rechacen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

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KEEP POSTED IN A CONSPICUOUS PLACE. COLOQUESE EN LUGAR VISIBLE.
WORK EXPOSURE TO BODILY FLUIDS
NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person’s blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM. Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. NO LATER THAN TEN (10) CALENDAR DAYS after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. NO LATER THAN TEN (10) CALENDAR DAYS after the possible significant exposure the employee has blood drawn, and NO LATER THAN THIRTY (30) CALENDAR DAYS the blood is tested for HIV OR HEPATITIS C by antibody testing and the test results are negative.

4. NO LATER THAN EIGHTEEN (18) MONTHS after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or NO LATER THAN SEVEN (7) MONTHS after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS’ COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

ICA Form 04-615-01
WC 7912a (8-01) UNIFORM INFORMATION SERVICES, INC.
**EMPLOYER’S REPORT OF INJURIOUS OCCURRENCE**

**COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS OF NOTICE OF ACCIDENT, FATALITIES MUST BE REPORTED WITHIN 24 HOURS.**

Employer must, on this form, notify his insurance carrier of every injury or death suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. Arizona Revised Statutes 23-906 & 23-1061

**INDUSTRIAL COMMISSION OF ARIZONA**

P.O. BOX 19070

PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

OSHA Case #: ____________________

RECORDABLE INJURY: __________

NON-RECORDABLE INJURY: __________

**EMPLOYEE**

1. LAST NAME 
2. M.I. 
3. SOCIAL SECURITY NUMBER* 
4. HOME ADDRESS (NUMBER & STREET) 
5. CITY STATE ZIP CODE 
6. TELEPHONE 
7. MARITAL STATUS: 
   - SINGLE
   - MARRIED
   - DIVORCED
   - WIDOWED

**EMPLOYER**

8. EMPLOYER’S NAME 
9. INDUSTRY CODE: 
10. NATURE OF BUSINESS (MANUFACTURING, ETC.) 
11. OFFICE ADDRESS (NUMBER & STREET) 
12. CITY STATE ZIP CODE 
13. PHONE

**ACCIDENT**

14. TIME OF EVENT
   - A.M.
   - P.M.
15. TIME EMPLOYEE BEGAN WORK
   - A.M.
   - P.M.
16. DATE EMPLOYER NOTIFIED OF INJURY
   - A.M.
   - P.M.

17. LAST DAY OF WORK AFTER INJURY
18. DATE OF RETURN TO WORK
19. EMPLOYEE’S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT
21. EMPLOYEE’S賦ED DEPARTMENT
22. DEPARTMENT NUMBER
23. DID INJURY OCCUR ON EMPLOYER’S PREMISES?
   - YES
   - NO

24. ADDRESS OR LOCATION OF OCCIDENT
   - CITY
   - COUNTY
   - STATE
   - ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than “hurt,” “pain,” or “sore.” Examples: “strained back,” “chemical burn, hand,” “carpal tunnel syndrome.”

26. PART OF BODY INJURED

27. FATAL
   - YES
   - NO
28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?
   - YES
   - NO
30. IF HOSPITALIZED, HOSPITAL NAME
   - ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

**CAUSE OF ACCIDENT**

32. WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet," "Worker was sprayed with chlorine when gasket broke during replacement," "Worker developed soreness in wrist over time."

33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "concrete floor," "chlorine," "radial arm saw." If this question does not apply to the incident, leave it blank.

34. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials," "spraying chlorine from hose sprayer," "daily computer key entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOYED CAUSED ACCIDENT, GIVE NAME AND ADDRESS

**EMPLOYEE’S WAGE DATA**

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED?
   - YES
   - NO
37. HOURS PER DAY EMPLOYEE WORKED WHEN INJURED
   - FROM A.M.
   - P.M.
   - THRU A.M.
   - P.M.
38. WAS EMPLOYEE ON OVERTIME WHEN INJURED?
   - YES
   - NO
39. NUMBER OF DAYS PER WEEK EMPLOYEE CUSTOMARILY WORKED
   - FROM A.M.
   - P.M.

**IMPORTANT**

40. DATE OF LAST HIRE
   - FROM A.M.
   - P.M.
41. WAS WORKER PAID FOR DAY OF INJURY?
   - YES
   - NO
42. IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR
44. GIVE EMPLOYEE’S WAGE STATUS AND SUMMARIZE MONTHLY/PERIODIC EARNINGS
   - FROM A.M.
   - P.M.
45. GIVE EMPLOYEE’S WAGE STATUS AS APPLICABLE
   - Hourly
   - Day
   - Week
   - Month
46. GIVE EMPLOYEE’S WAGE BASIS AS APPLICABLE
   - Hourly
   - Day
   - Week
   - Month
   - Lodging
   - Board
   - Both

47. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 36 CALENDAR DAYS PRECEDING INJURY (EXAMPLE: IF INJURED APRIL 15, GIVE EARNINGS FROM MARCH 9 THRU APRIL 15)
   - FROM A.M.
   - P.M.
48. WHAT IS THE BASIS OF PAYMENT?

**IMPORTANT**

49. IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING INJURY
   - FROM A.M.
   - P.M.
51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY
   - FROM A.M.
   - P.M.

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY
53. WAGE BEFORE INCREASE
54. WAGE AFTER INCREASE
55. GROSS EARNINGS FROM DATE OF INCREASE THROUGH DAY PRIOR TO INJURY

**AUTHORIZED SIGNATURE**

DATE

AUTHORIZED SIGNATURE

NOTE TO EMPLOYER:
1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

*The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commissions forms, prescribed under the Commission’s rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.*

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04-0101 (Rev. 7/01)
WC 84184 (7-01) UNIFORM INFORMATION SERVICES, INC.