Berkeley
PUBLIC SCHOOLS
Berkeley Unified School District

What To Do If Your Employee is Injured At Work

If your employee is injured at work and the bodily harm is life or limb threatening, dial 911.

If your employee's injury is considered an emergency, proceed to the nearest emergency room.

Otherwise, before you allow your employee to leave the work site you must do the following:

Step 1
Supervisor and Injured employee immediately call the Company Nurse at (877) 247-1447, Group Code: BRKLY to report the injury/illness. The Company Nurse is available 24/7.

Step 2
Complete the appropriate forms in the Workers Compensation Packet (WCP) if you have the WCP forms available or print from the BUSD Risk Management website.

Otherwise, upon notification by the Company Nurse Report of Injury the Workers' Compensation Office will email the WCP forms to employee and supervisor.

- Employee Forms

What to Do if You are Injured at Work (Employees)
Employee's Acknowledgement of Receipt
Workers' Compensation Claim Form DWC 1 (Questions 1 through 9)
Report of Incident
Witness Statement
BUSD Workers' Compensation Policy

- Supervisor Forms

What to Do if Your Employee is Injured at Work
Workers' Compensation Claim Form DWC 1 (Questions 10 through 19)
Supervisor's Report
BUSD Workers' Compensation Policy

Step 3

Seeking Medical Treatment After Injury/illness:

Kaiser Oakland Occupational Center is the Berkeley Unified School District (BUSD) treatment facility for injury/illness. If your employee seeks treatment with any other physician, without having a pre-designated physician on file; Workers' Compensation is **not** obligated to pay for treatment.

After 30 days of treatment with Kaiser Oakland Occupational Center your employee may change treating physicians with proper authorization. Contact Risk Management Department/Workers' Compensation Office for information.

Kaiser Oakland Occupational Center
3702 Broadway Avenue, 5th Floor, Suite 501, Oakland, CA 94611 (510) 752-124
Office Hours: Monday through Friday from 8:00 AM to 5:30 PM

Kaiser Oakland Medical Center-After Hours/Urgent Care
275 W. MacArthur Blvd, Oakland, CA 94611 (510) 752-1190
Office Hours: Monday through Friday after 5:30 PM and weekends

Pre-Designated Physician
The Personal Physician Pre-Designation form is valid only if your employee is in accordance with pre-designation regulations. Contact the Risk Management Department/Workers' Compensation Office for information at (510) 644-2879 or send an email to riskmanagement@berkeley.net.

Step 4

Provide **any** updates and **all** work status reports to the Risk Management Department/Workers' Compensation Office.

Additional Responsibilities

- It is absolutely mandatory that for each day(s) your employee is out, the employee must enter an absence in Frontline. (Frontline Education - Absence Management formerly AESOP). If the employee is unable to do so, please enter for the employee. https://login.frontlineeducation.com/login?signin=78c9a32258102b10294e74e46cf5ba4c&productId=ABSMGMT&clientId=ABSMGMT#/login

Contacts

Berkeley Unified School District **Risk Management Department/** **Workers Compensation Office** ***Michelle Payton*** ***Senior Workers' Compensation Specialist*** **Direct Phone: (510) 644-2879** **Direct Fax; (510) 644-8881** **Mailing Address: 2020 Bonar Street, 2nd Floor, Suite 234, Berkeley, Ca. 94702** **Email: riskmanagement@berkeley.net** **Website: berkeleyschools.net**	**Intercare Holdings Insurance Services, Inc.** ***Luz Amezcua*** ***Workers' Compensation Senior Claims Examiner*** **Direct Phone: 916-780-3613** **Direct Fax: 916-781-5606** **Mailing Address: P.O. Box 211012, Eagan, MN 55121** **Email: lamezcua@intercareins.com** **Website: intercareins.com**

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

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.

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.

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. 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 benficios 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.

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. ☐ 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 compañia de seguros o agencia adminstradora de seguros.* _____
    Intercare Insurance Holdings, Inc. PO BOX 211012 Eagan MN 55121
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 <u>one working day</u> 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 <u>un día hábil</u> 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*

Berkeley PUBLIC SCHOOLS
Berkeley Unified School District

SUPERVISOR'S REPORT

[Form RM-05] Rev. 09/2015

The statement of a(n):
- ☐ DIRECTOR
- ☐ MANAGER
- ☐ SUPERVISOR
- ☐ LEAD/ COORDINATOR
- ☐ Other:

EMPLOYEE'S INFO

EMPLOYEE'S NAME:	JOB TITLE:	SOCIAL SECURITY NO:
HOME ADDRESS:	WORK PHONE:	
CITY, STATE and ZIP:	HOME PHONE:	
SEX: [ ] Male [ ] Female	DATE OF BIRTH:	EMPLOYMENT STATUS: [ ] Perm/Full Time [ ] Perm/ Part-time [ ] Substitute [ ] 9 mo [ ] 10 mo [ ] 11 mo [ ] 12 mo [ ] Other: _____

LOCATION of INCIDENT (i.e. address, particular part of the building, etc. – include as much detail as possible)

WHERE WERE YOU in RELATION to the INCIDENT WHEN it OCCURRED?

DATE YOU WERE NOTIFIED:	TIME: AM / PM	WAS ANYONE ELSE INJURED in THIS INCIDENT?: ☐ YES ☐ NO ☐ UNKNOWN
NAME of OTHER INJURED PARTY: (if applicable)		TYPE of INURY/ILLNESSS IF KNOWN:
Was there any PROPERTY DAMAGE ? ☐ YES ☐ NO	Does the employee need to seek medical treatment? Yes [ ] No [ ]	Was employee referred to CompanyNurse (if applicable.):

DESCRIBE HOW the INCIDENT OCCURRED (include complete names of parties involved and make sketches, if appropriate):

☐ SKETCH ON BACK

DESCRIBE ANY APPARENT DAMAGE to PROPERTY (What was damaged and describe damage, i.e., : truck bumper, dented; car windshield, cracked)

IN YOUR OPINION WHAT WERE the ROOT CAUSES of the INCIDENT:

Has employee missed any time from work? Yes [ ] No [ ] What was last day of work: ___/___/____ Has employee returned to work? Yes [ ] No [ ] When did they return to work: ___/___/____	Have you provided a claim form to the employee with a work comp packet?: Yes [ ] No [ ] When was form provided: ___/___/____

This form must be completed immediately upon knowledge of an accident and submitted to Risk Management at: (510) 644-8881 or e-mail to: riskmanagement@berkeley.net. FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS. Thank you.

SUPERVISOR'S NAME:	SUPERVISOR'S SIGNATURE:	DATE:
JOB TITLE:	WORK LOCATION:	WORK PHONE:

Berkeley
PUBLIC SCHOOLS
Berkeley Unified School District

GENERAL

Pursuant to Workers' Compensation Law for the State of California, through its Self-Insured Workers' Compensation Program, the Berkeley Unified School District (District) shall provide statutory benefits including medical expenses, temporary compensation and benefits for permanent disability or death as required by the Act to employees who incur an injury or illness arising out of and in the course of their employment. The amount and type of benefits available vary depending upon the specifics of each situation.

This policy sets forth the District's commitment to the prevention of on-the-job accidents; treatment, care and rehabilitation of an employee; and the employee's rights and responsibilities when an on-the-job injury occurs; while protecting the financial integrity of the District. Please note that the provisions within this document are subject to change based on the laws governing Workers' Compensation.

EXCLUSIVE / NO FAULT STANDARD

Workers' Compensation is the exclusive remedy for employees injured on-the-job. It establishes, under most circumstances, a no fault system that focuses on health recovery with an emphasis on getting employees back to work.

INSURANCE COVERAGE AND CLAIMS ADMINISTRATION

Self-Insurance

On January 1, 2004, the District became self-insured for its workers' compensation insurance. As a self-insured entity, the District pays claims directly from District funds rather than paying premiums to an outside insurance agency. As a result, the number and magnitude of claims has a direct effect on the monetary resources of the District. To the extent we reduce claims, both in number and size; we can reallocate those monetary resources to other District priorities, including employee compensation and/or the educational program.

Claims Administration - Third Party Administrator (TPA)

The District utilizes a Third-Party Administrator (TPA) to administer and manage its Workers Compensation Program benefits and processes, to include claim and benefit dispute matters. The Districts Workers Compensation TPA is Intercare.

SAFE WORK ENVIRONMENT

The District strives to make the workplace a safe and healthy environment for all persons including students, faculty, staff and visitors. The key to a safe environment is the prevention of on-the-job accidents before an injury occurs. This responsibility is shared by all, and everyone is encouraged to bring work-related health and safety concerns to their supervisor/designee and/or the District's Risk Management Department as soon as possible. Supervisors must conduct periodic safety inspections of all work areas under their control. Employees will perform jobs in a safe manner with concern and care for their safety and the safety of others. Assistance is available from the Risk Management Department.

REPORTING PROCEDURES

The procedures within this section are to be followed when an employee sustains a work-related injury or illness. These procedures conform to existing California Workers' Compensation laws and facilitate the delivery of appropriate benefits. Upon notification of the accident, the immediate supervisor or designee shall provide the employee with the District's Worker's Compensation Claim Packet. The immediate supervisor or designee will ensure all applicable forms are received **within one working day** of receipt from the employee and submitted to the Risk Management Department. Regardless of the severity, or the need for medical treatment, employees must immediately report on-the-job accidents, injuries or illnesses to their supervisor.

CAL/OSHA requires fatalities and serious injury/ illnesses; including hospitalization, be reported to OSHA within the first 8 hours of the injury. Therefore, the immediate supervisor or designee shall report all accidents **within 6 hours** of the injury to the Risk Management Department, by phone and/or facsimile (FAX). In relation to this subject matter, only the Risk Manager or designee shall speak on behalf of the District to Cal/OSHA.

Accident Reporting - Employee Electing Treatment

Employees electing to seek medical treatment, along with the supervisor shall complete the Workers' Compensation Packet. The Workers' Compensation Packet includes the Employee's Acknowledgement of Receipt, Workers' Compensation Claim Form DWC 1, Incident Report, Witness Report and Supervisor's Report. The employee's supervisor shall sign the "Employer" section of all applicable forms. If there are any witnesses to the accident they may also complete the Witness Report and submit with other relevant forms. All documents are to be forwarded to the Risk Management Department **within one (1) work day** of receipt of the form from the employee. A copy of each form should be retained at the site or department for record. *By law, a claim is opened (not accepted) when the employer receives the DWC-1.* Employees should not submit the DWC-1 form if it is not their intention to file a claim.

Accident Report - Employee not Electing Treatment

When an employee elects not to receive medical treatment, the employee and the immediate supervisor, shall complete the Report of Incident form. Completion of the form preserves the employee's rights under Workers' Compensation. The form should be completed as soon as possible, but **no later than 2 work days** after the injury occurs.

Suspected Reoccurrence or Aggravation of a Prior Injury

When an employee suspects and/or experiences a re-occurrence/aggravation of the original injury, the employee and immediate supervisor are to complete the process as a new claim above and contact the physician for the original injury. The employee shall also contact the claim examiner at the TPA who processed the original claim for additional instruction. Until the physician certifies that the employee has experienced an aggravation of a prior injury/illness or if the employee has sustained a new injury, the claim will be handled as new and benefits will be placed on delay.

MEDICAL TREATMENT

The Workers' Compensation Program will pay for appropriate medical treatment of a compensable claim. Medication prescribed by the treating physician may also be provided under Workers' Compensation. If an employee has a prescription filled by a non-participating pharmacy, then the employee will pay out of pocket and request reimbursement from the TPA. An employee experiencing a work-related injury or illness electing to seek medical care shall do so in accordance with the District's policy and the medical treatment guidelines used under California's Workers' Compensation Act.

Medical Treatment Authorization

District medical treatment authorization to its designated Occupational Health Center is done on a District referral form. An injured employee is to contact the Company Nurse at the time of injury, or as soon as possible by calling (877) 247-1447, Group Code: BRKLY. The Company Nurse will make the referral and advise the injured employee to schedule an appointment at Kaiser Oakland Occupational Health Center, by calling (510) 752-1244. If necessary, the employee's supervisor may contact Company Nurse on behalf of the employee. All medical treatment referrals for employees must be reported to Risk Management Department via phone and/or email, by contacting:

Risk Management Department/Workers Compensation Office Telephone: (510)-644-2879
Fax: (510) 644-8881 or email: riskmanagement@berkeley.net

Treatment Facility

Kaiser Occupational Health Center
Normal Business Hours: Monday-Friday, 8:00 AM - 5:30 PM
3701 Broadway Avenue, 5th Floor, Suite 501 Oakland, CA. 94611
(510) 752-1244

Kaiser Oakland Medical Center - After Hours / Urgent Care Hours:
Monday-Friday, after 5:30 PM and open on weekends
275 W. MacArthur Blvd. Oakland, CA. 94611
(510) 752-1190

Please be advised that all employees are to be seen at the Occupational Health Clinic named above unless the following exceptions apply: (1) The employee is away from the District on District authorized business and requires immediate care, (2) The injury requires emergency hospital care, (3) A written Physician Pre-Designation form authorizing the employee treatment by their own primary treating physician is on file in the Risk Management Department prior to the injury, and (4) After 30 days from the date of reported injury, an employee may change from the District's approved medical provider and choose their own primary physician. However, the employee must notify the District/Risk Management Department and the TPA in writing of this change. The TPA will review the request and process accordingly.

Failure to comply can jeopardize coverage under the Workers' Compensation Act.

EMERGENCIES

Life Threatening in Nature

When an injury or illness is life threatening in nature, such as loss of limb or a severe burn, call 911 to be seen at the nearest emergency facility. Any follow up treatment must be with the Kaiser Oakland Occupational Health Center listed in the above section. An employee's supervisor must contact the Risk Management Department in the time frame noted under section ***"Reporting Procedures."***

Urgent, but not Life Threatening in Nature

If there is an urgent work-related injury and it is necessary for the employee to visit a doctor immediately assist the employee to:

Kaiser Oakland Medical Center, Emergency Care
275 W. MacArthur Blvd.
Oakland, CA. 94611
(510) 752-1190

MISSED WORK

Physician Certified Leave of Absence

The employee is required to attach the physician's statement or work status report to the Frontline System (formerly Aesop) for all missed days due to an injury or illness upon the return to work. The employee's immediate supervisor will enter the absence on behalf of the employee in the event the employee has not returned to work. In order to return to work, the employee is **required** to have a physician's statement or work status report that certifies the employee is released to full duty or modified duty and to provide a copy to the immediate supervisor and the Risk Management Department before starting work.

Time missed on the day of the injury

An employee's sick, annual or personal leave is not charged for time lost to seek medical treatment the day of the injury.

Employees are expected to return to work after the injury, unless the treating physician provides a statement certifying that the employee is not medically fit to return to work and is either off work or on modified duty/restrictions. **Prior** to returning to work, the employee must submit the physician's note/work status report to the supervisor and the Risk Management Department certifying the employee is able to return to work at full capacity.

Medical Appointments

If the physician determines that additional appointments are needed (i.e. physician and/or physical therapy), the employee should schedule the appointments outside of work hours. Under Workers' Compensation law, the employer is **not required** to provide compensation for time taken off during the work day to attend medical appointments. If medical appointments are scheduled during work hours, the employee will use sick, vacation, or any other paid leave. *Reference: BCCE Union Contract, 11.2.2. (a), page 40 and BFT Union Contract, 12.2.7, page 53.*

Non-Medical Appointments

When an appointment is set on behalf of the injured employee by the TPA's assigned claim examiner, compensation for that day is paid by Intercare. The injured employee is not required to use sick, vacation or any other paid leave. Examples of non-medical appointments could include QME appointments, second opinions, court appearances and/or depositions.

WAGE COMPENSATION

60 Days of Industrial Leave

Per Education Code 45192, each employee with an **accepted** workers' compensation claim is entitled to 60 days of Industrial Leave. Industrial Leave is governed by a physician's note. The deduction of Industrial Leave will begin the first day an injured employee is off of work by the treating physician. The deduction will end once the employee has returned to work. The injured employee is entitled to no more than 60 days per claim. Industrial Leave will not accumulate from year to year. However, if the 60 days overlap into the next consecutive fiscal year, the injured employee is entitled to the remaining balance of days. Industrial Leave is reduced by one day for each day of authorized absence, partial days cannot be deducted from Industrial Leave. Total wage compensation cannot exceed 100% of employee normal daily wage or salary. The Risk Management Department is responsible for tracking an employee's 60 days of Industrial Leave.

Temporary Disability (TD)

Workers' Compensation law states that each employee with an **accepted** workers' compensation claim is entitled to temporary disability payments for each authorized absence supported by a physician's note. Once an employee has exhausted 60 Days of Industrial Leave, Intercare will compensate wages for loss time. Intercare will pay two/thirds (2/3) of the injured employee's daily wages or salary, for each day of an authorized absence.

Integration of Paid Leave with Temporary Disability {TD)

Each employee with an **accepted** workers compensation claim is entitled to integration of paid leave with temporary disability for each authorized absence supported by a physician's note. Examples of paid leave included sick leave and vacation leave. The District will automatically integrate the 2/3 of temporary disability with sick leave in 1/3 increments, to insure full wages. Once sick leave has been exhausted, the employee has the option to integrate vacation leave in 1/3 increments. Once the injured employee has exhausted sick leave and vacation leave, the employee is entitled to Extended Sick Leave per the employee's collective bargaining agreement. Temporary Disability cannot be integrated with Extended Sick Leave as the total wage compensation cannot exceed normal daily wage or salary.

Permanent Disability

An injured employee who has been deemed Permanent & Stationary (P&S), has reached Medical Maximum Improvement level (MMI). Once deemed P&S, the injured employee is no longer entitled to temporary disability (TD). Instead the employee will be paid Permanent Disability (PD). The PD advances are separate and distinct from work loss time. It is meant to pay the injured employee for loss of earning capacity. It is not meant to replace wages while off work. Permanent disability is calculated by Workers Compensation law and payments are sent directly to the employee from Intercare. If an injured employee takes time off work due to the injury or for medical appointments; it is treated like normal loss time. The injured employee's sick, vacation or other available paid leave will be utilized for the time missed.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employee experiences a job-related injury or illness that meets the definition of an FMLA qualifying event, Human Resources shall notify the employee of being placed on FMLA leave. The number of unpaid leave days under FMLA an employee is eligible to receive is reduced by the time off covered under Workers' Compensation. Employees must contact Human Resources to acquire additional information regarding FMLA.

RETURN TO WORK

To assist injured employees in their recovery the District provides temporary duty in the form of modified or alternative work whenever possible. A copy of the physician's note, or work status report that places the employee on modified duty is provided to the supervisor and Risk Management Department.

The District utilizes a Third-Party Administrator (TPA) to administer and manage the Return-to-Work Program. The District's Return-to-Work TPA is **Norm Peterson & Associates (NPA).** If an employee is returned to work with restrictions NPA will coordinate with the employee's supervisor, host locations, physicians, and the Risk Management Department. If modified duty cannot be accommodated by the work site or host location the employee may be placed on temporary disability in accordance with Section 8.2 and applicable Workers' Compensation laws. Notification of this decision will be provided to the employee by Intercare.

Temporary modified duty is generally offered for ninety (90) work days, excluding weekends and District paid holidays. Employees requiring modified duty beyond this period of time, by the physician, may be placed on temporary disability in accordance with applicable Workers' Compensation laws. Notification of this decision will be

provided to the employee by Intercare. A temporary modified duty assignment at the employee's worksite or host location is limited to their school term, 10-11-12 months.

Employees electing not to participate in the District's Return to Work Program will not be allowed to utilize vacation leave to cover days missed from work and will be subject to leave policies associated with applicable collective bargaining unit agreements. The District's Workers' Compensation Program will not pay for these related absences.

Employees who are released from modified duty and returned to work at full capacity **are required** to provide a physician's note, or work status report certifying such to the supervisor and Risk Management Department **prior** to commencing work.

PHYSICIAN PRE-DESIGNATION

In compliance with Workers' Compensation laws, District employees can elect to pre-designate a physician for medical treatment. Pre-designation requests are to be submitted utilizing the forms provided by the Risk Management Department. Employees are responsible for the submission of this form, as well as the authorization from the designated physician. Employees can elect to pre-designate any time prior to an injury occurring.

Employees who DO NOT pre-designate a treating physician are to seek treatment at Kaiser Oakland Occupational Center for the first 30 days of an injury. After the 31th day an employee may elect to utilize their own primary treating physician, meeting requirements under Workers Compensation Law. Employees must notify in writing the intention to seek medical treatment from a medical provider outside of the Kaiser Oakland Occupational Center.

Contacts

Berkeley Unified School District	**Intercare Holdings Insurance Services, Inc.**
Risk Management Department/Workers Compensation Office	Intercare Workers Compensation Claims Office
Michelle Payton	Luz Amezcua
Senior Workers' Compensation Specialist	Workers' Compensation Senior Claims Examiner
Direct Phone: (510) 644-2879	Direct Phone: 916-780-3613
Direct Fax: (510) 644-8881	Direct Fax: 916-781-5606
Mailing Address: 2020 Bonar Street, 2nd Floor, Suite 234, Berkeley, Ca. 94702	Mailing Address: P.O. Box 211012, Eagan, MN 55121
Email: riskmanagement@berkeley.net	Email: lamezcua@intercareins.com
Website: berkeleyschools.net	Website: intercareins.com

California Department of Industrial Relations
California Department of Workers' Compensation

Workers' Compensation in California: A Guidebook for Injured Workers.
https://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

This guidebook gives an overview of the California workers' compensation system. It is meant to help workers with job injuries understand their basic legal rights, steps to take to request workers' compensation benefits, and where to seek further information and help is necessary.

Information and assistance - Locations
https://www.dir.ca.gov/dwc/dir2.htm

The Information and Assistance Office provides information and assistance to employees concerning rights, benefits and obligations under California Workers' Compensation Law and for those who do not have an attorney to navigate the workers' compensation system.

Workers' Compensation Injured Employee Workshop
https://www.dir.ca.gov/dwc/workshop/workshop_english.htm
https://www.dir.ca.gov/dwc/workshop/Workshop_Spanish.htm

Injured on the Job? Need to know your rights? (DWC-CA.GOV)

Attend a free one-hour online presentation on workers' compensation available in English and Spanish.