WORKERS' COMPENSATION INFORMATION FORM

California Law guarantees certain benefits to employees who are injured or become ill because of their jobs.

Any Job-related Injury is Covered - even first-aid type injuries and work-related illnesses. The key is whether it was caused by the job. (Some injuries from off-duty social or athletic activity-for example, the company picnic or the department bowling team-may not be covered.) Check with your supervisor if you have questions.

Workers' Compensation Benefits Include: . . . . . .

*** Medical Care.** All medical treatment-without a deductible or dollar limit. Costs are paid directly by your employer's insurance company, so you should never see a bill.

Your employer will arrange medical treatment, usually by a specialist for the particular injury. If you want to change your doctor, notify your supervisor. If you are eligible, you may pre-designate your physician on page two of this form. To be valid, the predesignation must be agreed to and signed by your physician.

*** Payment for Lost Wages.** If you're temporarily disabled by a job injury or illness, you'll receive tax-free income until your doctor says you are able to return to work. Payments are two-thirds of your average weekly pay, up to a maximum set by state law. Payments aren't made for the first three days, however, unless you're hospitalized or unable to work more than 14 days.

If the injury or illness results in a permanent handicap, permanent disability payments will be made after recovery. If the injury results in death, benefits will be paid to surviving dependents.

*** Rehabilitation.** If the injury or illness prevents returning to the usual job, you may qualify for vocational rehabilitation benefits. If so, all costs are paid by your employer's insurance company.

In The Event Of A Work Injury: . . . . . .

1. Be sure first aid is given.
2. See that the injured employee is taken to a doctor or hospital, if necessary.
3. Report the injury IMMEDIATELY to your supervisor, manager or employer representative and request a claim form. Any delay in reporting an accident may delay workers' compensation benefits.
4. See your supervisor if you have questions about workers' compensation.

Acknowledgment of Receipt: . . . . . .

My signature below certifies that I have been given the above information and understand my rights in regards to Workers Compensation.

Employees Signature: _____ Date: _____

EMPLOYEE'S PHYSICIAN PREDESIGNATION FORM

You may predesignate a personal physician if you file this written notice of the predesignation with your employer. The **NOTICE MUST INCLUDE** the physician's signature of agreement to the predesignation, and one of the following conditions must apply:

- The employer provides the staff with nonoccupational group health coverage in a health-care service plan (such as an HMO/PPO program). or
- The employer provides nonoccupational health coverage in a group health plan or a group health insurance policy, per LC §4616.7.

The personal physician you predesignate must meet all of the following criteria:

- Employee's regular physician and surgeon,
- Employee's primary care physician,
- Licensed per the Business and Professions Code,
- Previously provided treatment to the employee,
- Retains employee's medical records and history, and
- **AGREES to be the predesignated physician and signs the form.** ***(This form is invalid without the Physician/Surgeon's Signature and Agreement.)***

Name of Physician or Surgeon: . . . . . .

Address: . . . . . .

Employee's Signature: . . . . . .

Employee's Printed Name: . . . . . .

Date: . . . . . .

Employees can obtain a pre-designation form from their supervisor upon request. Contact your supervisor for more information.

I, the named, predesignated physician or surgeon, state that I meet all of the following criteria:

- I am the above-listed employee's regular physician and surgeon,
- I am the above-listed employee's primary care physician,
- I am licensed per the Business and Professions Code,
- I have previously provided treatment to the employee,
- I retain the I am the above-listed employee's medical records and history, and
- **I AGREE to be the predesignated physician and have signed the form to so attest.**

Name of Physician or Surgeon: . . . . . .

Address: . . . . . .

Physician's Signature: . . . . . .

Date: . . . . . .