HR EXPERTISE (HR KNOWLEDGE)

Risk Management
Medical Liaison Unit

Supervisor's Training 2021

Risk Management

- Workers' Compensation
- COVID - 19

- Reasonable Suspicion
- Fitness for Duty
- Medical Evaluations
- Funeral Guidelines
- Officer Involved Shooting Procedure

- Ergonomic Evaluations
- Cal/OSHA Compliance
- Safety Programs
- Field Safety Officers (FSO)

Workers' Compensation

Work Related Injuries or Illnesses

Benefits Include:

- Medical Treatment
- Mileage Reimbursement
- Compensation for Lost Time
- Permanent Disability
- Death Benefits

Eligibility:

- Paid Employees
- Volunteers

Work-Related Injuries

- **Specific Injury**
- **Cumulative or Repetitive Trauma**

The form should be utilized and included when reporting work related injuries. This is designed to ensure all appropriate forms are completed.

3 FULL WORK COMP CLAIM

Injured employee is seeking **MEDICAL TREATMENT** and/or **LOST TIME** from work.

- ☐ MLU-4 Report of Occupational Injury
- ☐ RM-3 Supervisor Investigation
- ☐ DWC-1 Employee's Claim for Workers' Comp. Benefits
- ☐ MLU-6 Proof of Service Form
- ☐ MLU-7 Medical Authorization for Release of Information Service
- ☐ MLU-8 Non-medical Authorization for Release of Information Service
- ☐ MLU-1 Medical Disability Status Report
- ☐ MISC-1 Sharps Injury Log (OSHA) *

*To be completed if a "sharps object" was involved and kept on file in the "SHARPS LOG".

1 DOCUMENT ONLY

Employee wants to **DOCUMENT** an injury, no lost time or medical treatment involved.

- ☐ MLU-4 Report of Occupational Injury
- ☐ RM-3 Supervisor Investigation

2 EXPOSURE

Employee has no injury or illness and wants to seek **preventative care** due to an **EXPOSURE** (Example: blood borne pathogens or a TB exposure)

- ☐ MLU-4 Report of Occupational Injury
- ☐ RM-3 Supervisor Investigation

San Diego County Sheriff's Department

EMPLOYEE REPORT OF OCCUPATIONAL INJURY

☐ Full Claim
☐ Documentation Only
☐ Exposure

Employee Information

Employee Name: _____ Employee ID Number: _____
Home Address: _____ Home/Cell Phone Number: _____
Sex: ☐ M ☐ F ☐ Non-Binary Job Title: _____ Date of Birth: _____
Sheriff's Department/Location Assigned: _____ County Hire Date: _____
Work Hours/Day: _____ Workdays/Week: _____ Total Weekly Hours: _____
Work Phone: _____ Gross Wages/Hour: _____

Injury Information
(May be completed by supervisor if employee is unavailable)

Date of Injury: _____ Time of Day: _____ ☐ AM ☐ PM Date Reported: _____
Address where injury or exposure occurred: _____

In what county? _____ Was this on employer's premises? ☐ No ☐ Yes
What was the employee doing when injured? (Please be specific- identify tools, equipment or material the employee was using at the time.)

How did the injury or exposure occur? (Please describe in detail, what happened and how it happened.)

Object or substance that directly injured employee. (For example: Machine that struck, vapor or poison inhaled or swallowed, chemical which irritated skin; in case of strains, the object being pulled or lifted.)

Describe the injury or illness. (For example: Cut, strain, fracture, skin abrasion, etc.)

Part of body affected: _____
Name and address of treating physician: _____
Name and address of hospital (if hospitalized): _____
Do you have a Predesignation of Personal Physician on file with MLU? ☐ Yes ☐ No
Were you informed of Employee Assistance Program (EAP), The Counseling Team International, Peer Support, and Chaplain Services? ☐ Yes ☐ No

Supervisor Information

Supervisor's Name: _____
Work Phone: _____
Date Completed: _____
Did employee lose at least one full day's work after injury? ☐ Yes ☐ No
Has employee returned to work? ☐ Yes ☐ No
If "Yes," date last worked: _____

Scan and email a copy to Sheriff's Medical Liaison Unit (Liaison.Medical@sdsheriff.org) immediately.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

DEPARTMENT & DIVISION	NAME OF PERSON FILLING OUT REPORT (PRINT)		
LOCATION OF ACCIDENT	DATE OF OCCURRENCE	TIME ☐AM ☐PM	DATE REPORTED

PERSONAL INJURY		PROPERTY DAMAGE	
INJURED'S NAME		PROPERTY DAMAGED	
OCCUPATION	INJURED PART OF BODY	ESTIMATED COSTS	ACTUAL COSTS (LEAVE BLANK)
NATURE OF INJURY		NATURE OF DAMAGE (IF NONE, PLEASE STATE)	
OBJECT/EQUIPMENT/SUBSTANCE INFLICTING INJURY		OBJECT/EQUIPMENT/SUBSTANCE INFLICTING DAMAGE	
PERSON WITH MOST CONTROL OF OBJECT/EQUIPMENT/SUBSTANCE		PERSON WITH MOST CONTROL OF OBJECT/EQUIPMENT/SUBSTANCE	

DESCRIPTION

DESCRIBE CLEARLY HOW THE ACCIDENT OCCURRED

WITNESSES

LIST NAMES AND CONTACT INFORMATION FOR ANY WITNESSES TO THIS INCIDENT

ANALYSIS

WHAT ACTS, FAILURES TO ACT AND/OR CONDITIONS CONTRIBUTED MOST DIRECTLY TO THE ACCIDENT?

WHY DID THE ABOVE ACTS, FAILURES TO ACT AND/OR CONDITIONS EXIST?

LOSS SEVERITY POTENTIAL			PROBABLE RECURRENCE RATE		
☐ MAJOR	☐ SERIOUS	☐ MINOR	☐ FREQUENT	☐ OCCASIONAL	☐ RARE

PREVENTION

WHAT ACTION HAS OR WILL BE TAKEN TO PREVENT RECCURENCE? PLACE AN X BY ITEMS COMPLETED

SIGNATURE OF IMMEDIATE SUPERVISOR	DATE	SIGNATURE OF DEPARTMENT HEAD or DESIGNEE	DATE

PRINT CLEAR

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.* **County of San Diego Sheriff's Department**
11. Address. *Dirección.* **5530 Overland Avenue #210, San Diego, CA 92123**
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 compañía de seguros o agencia adminstradora de seguros.* **self-insured**
16. Insurance Policy Number. *El número de la póliza de Seguro.* **n/a**
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 **one working day** 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 compañia de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil 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*

Date of injury

Employee wet signature is required

Supervisors don't forget to sign

Must provide SSN

All three dates are needed – can be different dates

PROOF OF SERVICE

I, _____, received an Employee's Claim for Workers' Compensation Benefits form and Notice of Eligibility for Workers' Compensation Benefits on _____.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

_____ _____

Employee Signature Date

PROOF OF SERVICE BY SUPERVISOR or DHRO

I, _____, declare I am, and was at the time of this service, over 18 years of age. I served an Employee's Claim for Workers' Compensation Benefits form and Notice of Potential Eligibility for Workers' Compensation benefits on _____ by:

- ☐ In person
- ☐ By email. Email address: _____
- ☐ By fax. Fax number: _____
- ☐ By U.S. Mail in a sealed envelope with postage prepaid, and addressed to:

_____

_____

_____

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

_____ _____

Supervisor/DHRO Signature Date

Department of Human Resources – Risk Management Division
Medical Authorization to Obtain and Release Information
In Connection With an Application for Workers' Compensation Benefits

Name: _____ Date of Birth: _____
Claim #: _____ WCAB# _____

I am seeking workers' compensation benefits in connection with a claimed industrial injury. **I authorize** any *physician, hospital, other medical practitioner, medical facility, insurance company, Veterans Administration, Medi-Cal Information Bureau, the Social Security Administration, San Diego County Retirement Association (medical information)* to **release records to the County of San Diego or to its designated agent**, including any and all information which they may have about any diagnosis, treatment, and prognosis regarding my physical condition.

I understand that the information the County of San Diego is authorized to obtain will be used to determine my entitlement to workers' compensation benefits. I understand that upon written request, I have the right to learn the contents of such information, unless they are made confidential by Section 5328 of the Welfare and Institutions Code of the State of California.

I also authorize the County of San Diego to disclose any information obtained to any physician, insurer, or other person or organization for their use in performing medical services in connection with my application for workers' compensation benefits, or as may be otherwise lawfully required.

I agree that this authorization shall be valid for 24 months from the date shown below. I understand that I have a right to ask for and receive a true copy of this authorization signed by me and that a reproduced copy of this authorization shall be as valid as the original.

I authorize the staff of the above named entities to furnish the information as directed in this authorization. I further agree to release the entity and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

Employee wet signature is required

Signature: _____ Date: _____

_____

If the injury claimed is for psychiatric/stress related condition or, if sensitive records release is required by the facility from which records are required, also sign the following:

The above captioned workers' compensation case involves a claimed psychiatric disability or other sensitive issues. Therefore, this release expressly extends to the release of records and reports involving psychological and/or psychiatric treatment, treatment for drug and/or alcohol abuse, or treatment related to the patient's HIV status.

Employee wet signature is required

Signature: _____ Date: _____

Please return the signed authorization form to:
County of San Diego, Workers' Compensation Division
5530 Overland Avenue, Suite 210, San Diego, CA 92123

Department of Human Resources – Risk Management Division
Non-Medical Authorization to Obtain and Release Information
In Connection With an Application for Workers' Compensation Benefits

Name: Date of Birth:
Claim #: WCAB#

I am seeking workers' compensation benefits in connection with a claimed industrial injury. **I authorize** any *insurance company, Veterans Administration, Medi-Cal Information Bureau, the Social Security Administration, employer, San Diego County Retirement Association* to **release non-medical records to the County of San Diego or to its designated agent**, including any and all information which they may have about my employment, personnel records, wages, retirement records, and social security earnings.

I understand that the information the County of San Diego is authorized to obtain will be used to determine my entitlement to workers' compensation benefits. I understand that upon written request, I have the right to learn the contents of such information, unless they are made confidential by Section 5328 of the Welfare and Institutions Code of the State of California.

I also authorize the County of San Diego to disclose any non-medical information obtained to any insurer, other person or organization, for their use in performing legal services in connection with my application for workers' compensation benefits, or as may be otherwise lawfully required.

I agree that this authorization shall be valid for 24 months from the date shown below. I understand that I have a right to ask for and receive a true copy of this authorization signed by me and that a reproduced copy of this authorization shall be as valid as the original.

I authorize the staff of the above named entities to furnish the information as directed in this authorization. I further agree to release the entity and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

Employee wet signature is required

Signature: _____ Date: _____

Please return the signed authorization form to:
County of San Diego Workers' Compensation Division
5530 Overland Avenue, Suite 210
San Diego, CA 92123-1204

Form MLU - 8
Revised 8/11/12

Medical Providers

- Concentra

- Kaiser Permanente On-The-Job or KPOJ

- Pre-designated Physician Form

Work Status Reports

Full Duty (FD)

- Employee is able to perform all job duties

Temporary Limited Duty (LD)

- Work Restrictions
- Reasonable Accommodation
- Release Time for Light Duty Appointments
  - Kronos Timekeeping - Reason Code 803

Temporary Totally Disabled (TTD)

- Injury Leave – Non-Sworn / 4850-Sworn
- Use employee balances

Permanent & Stationary (P&S)

- Injury leave not approved; use up remaining 4850

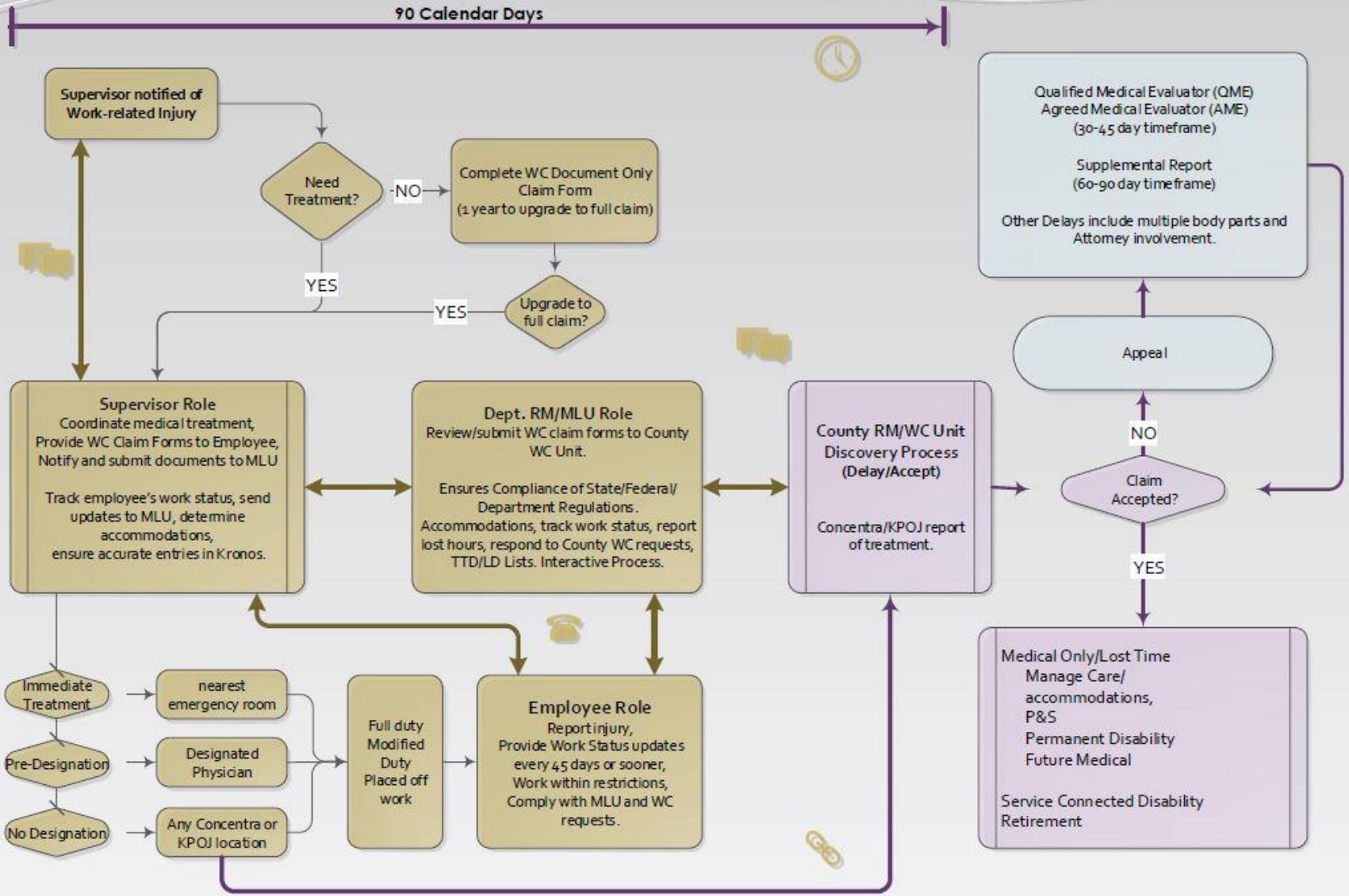
Supervisor's Role

- **Obtain correct & complete WC Forms**
  - Supervisor’s Accident Investigation Report – RM3
  - Report of Occupational Injury – MLU4
  - Workers’ Compensation Claim Form – DWC1
- **Notify MLU and Submit Forms**
- **Determine medical treatment**
- **Corrective Measures?**

Supervisor's Role (con't)

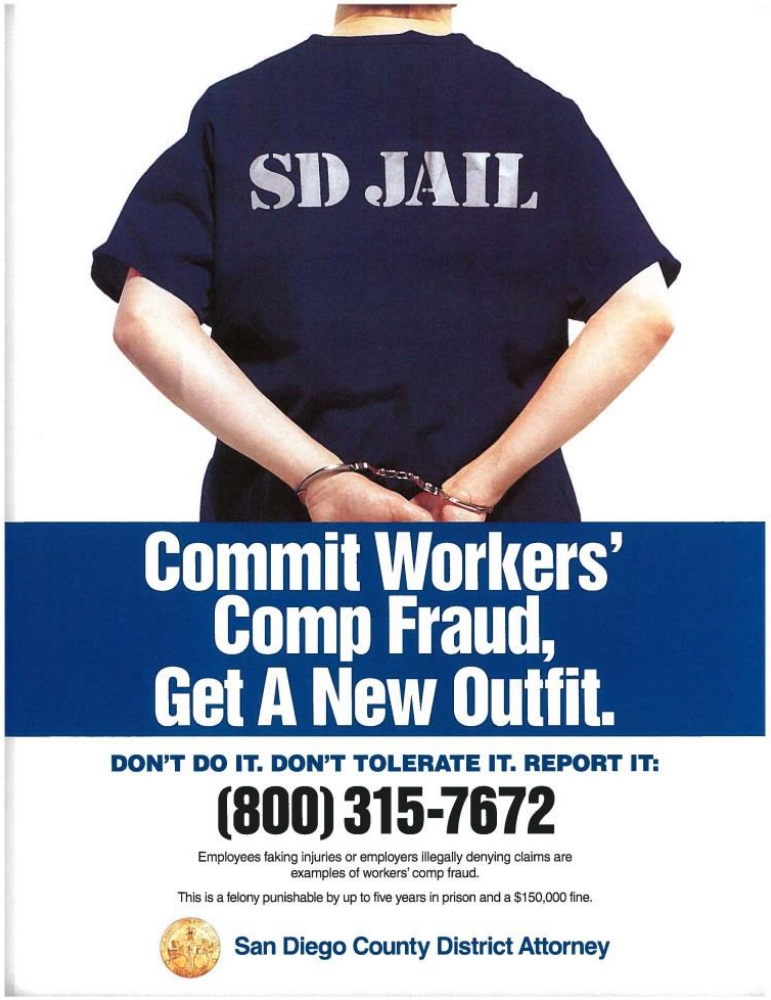
- Communicate with your employee & MLU
- Get updated work status notes & forward to MLU
- Determine reasonable accommodations if necessary
- Cooperate with WC investigation
- Make sure timecards are correct

Risk Management (RM)/Medical Liaison Unit (MLU) and County Workers' Compensation (WC) Claims Process



March 18, 2021

If fraud or abuse is suspected, contact MLU



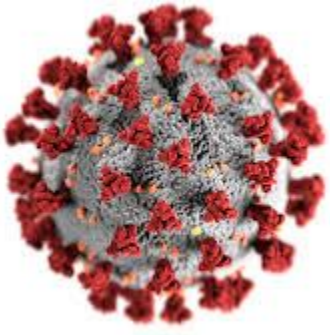

HR EXPERTISE (HR KNOWLEDGE)
TRAINING
HUMAN
RESOURCES
POTENTIAL
HR
People
Hiring
Performance
$$
Economy

COVID-19

COVID-19

- **Check "COVID Resources" link on Sheriff's home page for updates and forms**

-
  - **Questions about COVID**
  - **Report COVID positives & quarantines**
  - **Report return to work dates**
  - **Submit Contact Investigations/Tracing Reports**



COVID Contact Investigations – Part 1 of 2

XX Contact Investigation
Timeline as of August 5, 2021

August 2, 2021- Monday

- Worked at XX- (no symptoms)
- Attended Monday Meeting with whole team
- Stayed in the second floor office for most of the day
- Worked from 0900-1830

August 3, 2021- Tuesday

- Did not come into work
- Woke up with stuffy nose and dry throat
- Got COVID test

August 4, 2021- Wednesday

- Stayed home and did not come into work
- Received notification at 8:07 PM that he was POSITIVE for COVID

August 5, 2021- Thursday

- Stayed home and did not come into work

- Contact Investigation completed

CONTACTS

  - Lieutenant XXXX notified the following:
    - Facility/Workstations/work space was cleaned and disinfected
    - Advised staff to follow the safety prevention precautions
    - Stay home if sick
    - XXX- Notified due to attending meeting with XX and having a conversation at the food truck. She had the most contact with XX. XX also showing symptoms, took COVID test, and waiting for results. Stayed home Tuesday-Thursday.
    - XXX– Notified due to attending meeting with XX. No symptoms as of Thursday.
    - XXX- Notified due to attending meeting with XX. No symptoms as of Thursday.
    - XXX- Notified due to attending meeting with XX. XX also showing symptoms. Stayed home on Thursday.

COVID - Contact Investigations – Part 2 of 2

Instructions: The employee's Supervisor/Manager/Facility Commander should be notified that a Contact Investigation (CI) Staff Report is being conducted. This investigation should be completed within 72-hours of a positive COVID19 notification. The Administrative Sergeant/designated point of contact will be contacting employees directly regarding the potential exposure. Upon completion of the Contact Investigation, if it is determined that additional medical attention is needed the employee will be notified directly. If not, no further action is necessary. Any other questions the employee may have can be referred to contact MLU.

CONTACT INVESTIGATION STAFF REPORT Updated: 7/26/21

Employee Name: _____

Dates of Exposure Review: _____ (Go back 2-days prior to the onset of symptoms)

NAME	EMPL ID	Employee Job Title	AREA WORKED	LENGTH OF CONTACT [Note: > than 15 mins / < than 15 mins. Include the increments. (Ei. 5 X 5 min convo]	PHYSICAL CONTACT/ DISTANCE [Note: greater than 6 feet / less than 6 feet (Ei. Less than 6 feet when passed by in the hallway)	LIST PPE WORN BY STAFF [Ei.: N95 Mask / Cloth Mask / Gloves / Gown]	SUPERVSIOR/MANAGER NAME

2022 Supplemental Paid Sick Leave (SPSL)

Available from 1/1/2022 to 12/31/2022

Employees can request for up to 80 hours of SPSL if they are off for a COVID-related reason.

1. Up to 40 hours can be requested for:
    a. Vaccine-related
    b. Caring for yourself (or family member) with symptoms
    c. Caring for a child if school or daycare is unavailable due to COVID and employee is unable to telework
    d. Been told to quarantine/isolate in accordance with Fed/State/Cal-OSHA/Public Heath
2. Another 40 hours can be requested if employee tested positive for COVID or taking care of COVID positive family member.

Risk Management

Risk Management

- Sworn Qualification Periods for TTD or light duty employees
- Officer Involved Shooting (OIS)
  - Critical Incident Procedure
- Fitness for Duty
- Funeral Guidelines
- Ergonomic Evaluations

Medical Evaluations - Sworn

Fourth Year Physicals

- Needs to be completed prior to fifth year of service
- 1 year to complete

Omnibus Transportation Act

- Testing prior to starting position
- Monthly random drug testing

Probationary Drug Testing

- Monthly random selection for new sworn employees

Monthly Random Drug Testing

- Sworn (effective July 2014)

Cal/OSHA Compliance

Sheriff's Department's responsibilities:

- Establish, implement, and maintain an Injury and Illness Prevention Program (IIPP)
- Keep records of work-related injuries and illnesses - Facility Safety Officer Program
- Report work-related death or serious injuries or accidents to Cal/OSHA

Facility Safety Officer (FSO) Program

Risk Management Unit's Role:

- Create and maintain the program
- Encourage and promote participation
- Manage records
- Take a proactive approach to the safety and health of our employees
- Conduct monthly site safety inspections


QUESTIONS
ANSWERS