Workers' Compensation Program
Supervisor's Procedure Manual

RTD

SOUTHERN CALIFORNIA RAPID TRANSIT DISTRICT

Prepared by LJR Claims Administration Service

Rev. 5/85

WORKERS' COMPENSATION PROGRAM
SUPERVISOR'S PROCEDURE MANUAL

Revised 5/85
LJR, Inc.

TABLE OF CONTENTS

RTD

WORKERS' COMPENSATION PROGRAM

INTRODUCTION

The Labor Code of California mandates employers to provide Workers' Compensation benefits to workers who become ill/injured in the course and scope of their employment. Benefits include medical treatment and payment of medical expenses; payments (indemnity) including compensation for lost wages, permanent disabilities, and death.

District employees receive benefits through the District's self-insured program. The District's Workers' Compensation Representative coordinates the program with an outside Claims Administrator under contract to the District handling the claims processings.

The Claims Administrator is *LJR Insurance Services, Inc.*, P.O. Box 92387, Los Angeles, California 90009, (213) 216-6996.

They handle all post-injury complaints, control follow-up medical treatment, authorize and distribute benefit checks, and represent us before the Workers' Compensation Appeals Board.

Workers' Compensation procedures deal with events and circumstances <u>following</u> the illness/injury. What happens <u>after</u> an illness/injury has an important effect upon the employee's moral and the ultimate cost of the claim. The District recognizes that an ill/injured employee needs special attention and consideration.

The goal of this Workers' Compensation program is to ensure that employees having valid claims receive all benefits to which they are entitled and to return ill/injured employees to work as soon as possible. This goal may be realized through the following process:

1. Complying with applicable State and Federal laws and District Policy.
2. Informing the employee of rights and benefits under the Workers' Compensation Program.
3. Considering the special needs and problems of the ill/injured employee.
4. Arranging prompt and appropriate medical treatment.
5. Communicating with the employee throughout this process.
6. Documenting the accident and return-to-work records.
7. Defending the District against improper claims.
8. Maintaining and monitoring claims experience and financial records.
9. Participating in training sessions regarding handling on-on-the job injuries and Workers' Compensation claims.

The Insurance Department through its Workers' Compensation Section is responsible for:

1. Coordinating the District's internal Workers' Compensation procedures with those services provided by the outside Claims Administrator and the District employees.
2. Providing vocational rehabilitation services for qualified injured workers.
3. Authorizing questionable return-to-work of the ill/injured employee.
4. Assisting the operations by answering questions and providing information on the handling of special problems.
5. Maintaining permanent records of the District's Workers' Compensation program.
6. Integrating claims data with other programs (i.e., pre-placement and periodic physical examinations, safety, personnel performance records).
7. Monitoring the program.

The Safety Department is responsible for:

1. Overseeing the conduct of Accident Investigations.
2. Reviewing and analyzing audit data to monitor Safety and Loss Control Program effectiveness.
3. Compiling annual statistics related to Occupational Injuries to comply with State and Federal requirements.

The Personnel Department, through its Visiting Nurse, is responsible for:

1. Verifying return-to-work of the injured employees that were transferred to Indefinite Leave and advising the Workers' Compensation Administrator.
2. Placing injured employees released for temporary modified work into positions within the Special Assistants program.

The ability of the Workers' Compensation Section and the outside Claims Administrator to respond to claims largely depends upon the Supervisor's prompt reporting of all illness/injury claims. The Supervisor initiates the Workers' Compensation process and has primary responsibility to maintain contact with the injured employee until his/her return to work or a personnel status change occurs.

1. Communicate immediately and periodically with the employee throughout this process.
2. Assist in arranging for immediate treatment of the ill/injured employee and assist *LJR Insurance Services* in arranging further medical treatment.
3. Document the accident and notify *LJR Insurance Services* of the claim.
4. Notify *LJR Insurance Services* when you have been advised that the injured employee has been released to return to work.

The chart below illustrates the claims process for which the Supervisor is responsible, the required forms and the references to appropriate procedure sections of this manual.

PROCESS	SUPERVISOR	PROCEDURE	FORM NO.
Reports and documentation	Records events	A	64-1 64-5 32-43
Medical Service	Initiate treatment	B, C	64-4
Temporary Disability and Return to Work	Communicates with Employee and *LJR Insurance Services,* Work. Comp. Section & Visiting Nurse	D	32-3 38-97 22-115
Permanent Disability	Complies with Restrictions	E	64-4
Prevention of Recurrence	Investigates Injury and does on-the-job training	A	64-1 64-5

The procedures that follow are guidelines to assist you. If you have any questions, problems or unusual situations, please contact the Workers' Compensation Section at Extension 6664. Additional forms may be obtained from stationery.

A. REPORTING THE ILLNESS/INJURY

The Supervisor is responsible for reporting every work-related illness/injury as soon as it occurs. The District realizes that personal judgement in reporting injuries will occur, especially in the area of first aid. Injuries/illnesses that must be reported promptly are injuries involving muscle strains, back injuries, and exposures to toxic chemicals, etc. These types of occurrences should not fall under the heading of "first aid only". This reporting includes investigating, reconstructing and documenting the events and circumstances surrounding the work-related illness/injury. The following guidelines will assist the Supervisor in reporting findings.

1. EMPLOYEE/EMPLOYER REPORT OF INJURY (64-1)

As soon as practical after the occurrence, have the employee complete and sign the injury report. Then, the Supervisor attests to the information and signs it. This form is in four parts – the Department keeps the bottom (goldenrod) copy and forwards the original and one copy to *LJR Insurance Services* and the remaining (green) copy to the Safety Department.

Do not wait for the report from the Doctor before completing the original report of injury. The details of the accident shall be given in a simple statement of fact. In reply to Question 29, on the form, have the employee state in his own words the nature of the injury. We rely upon the doctors for an accurate description.

a. Complete Employee/Employer's Report Form No. 64-1 within 12 hours. Instructions are on the reverse side of the form.
b. Complete Medical Service Order/Return-to-Work Form No. 64-4 and give it to the employee to take to the doctor at the time of the injury.
c. Complete the Occupation Injury/Illness Investigation Report Form No. 64-5.
d. If the injury was due to a traffic accident, a copy of the accident report, Form No. 32-43, must also be attached to the Employee/Employer's Report and forwarded to *LJR Insurance Services.*

2. INVESTIGATION

a. Make direct inquiries of the injured employee as to:
   –What (s)he was doing
   –How the accident happened
   –Where it took place
   –When it occurred
   –Why it happened (cause)

b. Interview witnesses, one at a time, in regard to:
   —What they observed
   —What they heard (exact words, if possible).
c. Interview others who were indirectly involved (i.e. maintenance worker who repaired the ladder on which the employee was hurt).
d. Inspect the equipment, substance, or surroundings (i.e., broken rung on ladder, wet floor, etc.).
e. If appropriate, take pictures and/or provide drawings to help in the clarification of the accident.
f. Isolate and secure all faulty equipment in a safe area where it will not be altered or removed. Telephone the Safety Department on Extension 6545 to make arrangements for an immediate inspection of the item. Do not allow further use of the equipment without a clearance by the Safety Department.

3. CLAIMS ADMINISTRATION

The District contracts for Workers' Compensation Claims Administration Services with:

LJR INSURANCE SERVICES
P.O. Box 92387
Los Angeles, California 90009
(213) 216-6996

The Supervisor may be contacted by *LJR Insurance Services* for additional information regarding the employee and/or the illness/injury.

4. SERIOUS ILLNESS, INJURY AND HOSPITALIZATION

State law requires employers to immediately report every case involving death or a serious illness/injury. A serious illness/injury is defined as any work-related illness/injury which requires inpatient hospitalization for 24 hours or more, or results in loss of any part of the body, or any serious degree of permanent disability or death.

Therefore, during business hours, immediately report via phone to the Safety Department at Extension 6545, all cases you believe to be serious. After business hours, call the District Dispatcher on Extension 6111. This phone call does not relieve the Supervisor's responsibility to then complete the required forms.

B. MEDICAL TREATMENT: INITIAL AND EMERGENCY

Initial medical treatment is the first medical treatment or evaluation an employee receives following a work-related illness/injury.

The following guidelines also apply to emergency medical treatment. State law requires the employee to give the Supervisor notice of the injury. It is then the Supervisor's responsibility to see that medical treatment is offered. The employee is not required to ask for medical treatment.

1. ARRANGING TREATMENT

In arranging Initial and Emergency medical treatment, the Supervisor shall:

a. Direct the ill/injured employee to an authorized medical facility.

b. Authorize medical evaluation by furnishing the employee with the required form to present to the doctor/facility.

2. REQUIRED FORM – MEDICAL SERVICE ORDER (64-4)

a. To authorize treatment and receive an initial medical report, please furnish the treating doctor/facility with: Medical Service Order/Return-to-Work Form No. 64-4.

b. The Supervisor should review Form No. 64-4 when returned by the employee.

3. MEDICAL FACILITIES

When an employee reports a work injury, refer him to one of the medical facilities listed below. These physicians and medical facilities are qualified to provide the best in medical treatment.

WORKERS' COMPENSATION

MEDICAL PANEL

Division 1 – 1016 E. 6th Street, Los Angeles, Calif.

TEMPLE MEDICAL GROUP
124 N. Vignes St.
Los Angeles, Calif. 90012
Telephone: (213) 626-5679
Hours: 24 hours – 7 days

*ALAMEDA INDUSTRIAL MEDICAL GROUP
1907 E. Washington Blvd.
Los Angeles, Calif. 90021
Telephone: (213) 747-7667
Hours: 7:30 a.m. to 6:00 p.m. Mon–Fri

*After hours and Emergency: ORTHOPAEDIC HOSPITAL
2400 S. Flower
Los Angeles, Calif. 90007
Telephone: (213) 742-1000

Division 2 – 720 E. 15th Street, Los Angeles, Calif.

*METROPOLITAN MEDICAL GROUP
437 E. Washington Blvd.
Los Angeles, Calif. 90015
Telephone: (213) 747-0634
Hours: 7:00 a.m. to 5:00 p.m. Mon–Fri

* SHELTON-LIVINGSTON MEDICAL GROUP
1401 S. Hope Street, No. 202
Los Angeles, Calif. 90015
Telephone: (213) 749-2321
Hours: 7:00 a.m. to 10:00 p.m. Mon–Fri
9:00 a.m. to 4:00 p.m. Saturday

*After hours and Emergency: ORTHOPAEDIC HOSPITAL
2400 S. Flower
Los Angeles, Calif. 90007
Telephone: (213) 742-1000

Division 3 – 630 W. 28th Street, Los Angeles, Calif.

*NORTH MAIN MEDICAL
1744 N. Main Street
Los Angeles, Calif 90031
Telephone: (213) 225-2261
Hours: 8:00 a.m. to 6:00 p.m. Mon–Fri
9:00 a.m. to 4:00 p.m. Saturday

TEMPLE MEDICAL GROUP
124 N. Vignes Street
Los Angeles, Calif. 90012
Telephone: (213) 626-5679
Hours: 24 hours – 7 days

*After hours and Emergency: HOSPITAL OF THE GOOD SAMARITAN
616 S. Whitmer
Los Angeles, Calif. 90017
Telephone: (213) 977-2121

Division 4 – 7878 Telegraph Road, Downey, Calif.

SPECTRUM INDUSTRIAL MEDICAL CLINIC
4730 Eastern Avenue
Commerce, Calif. 90040
Telephone: (213) 728-9078
Hours: 24 hours – 7 days

*TELEGRAPH MEDICAL
6538 Telegraph Road
Commerce, Calif. 90040
Telephone: (213) 726-3212
Hours: 7:00 a.m. to 11:00 p.m. Mon–Fri
7:00 a.m. to 3:00 p.m. Saturday

*After hours and Emergency: BEVERLY HOSPITAL
309 W. Beverly
Montebello, Calif. 90640
Telephone: (213) 723-0951

Division 5 – 5425 Van Ness, Los Angeles, Calif.

*BALDWIN HILLS MEDICAL
5753 Rodeo Road
Los Angeles, Calif. 90016
Telephone: (213) 857-1144
Hours: 9:00 a.m. to 9:00 p.m. Mon–Sat

*CENTRAL INDUSTRIAL MEDICAL
5970 Central Avenue
Los Angeles, Calif. 90001
Telephone: (213) 233-3377
Hours: 7:30 a.m. to 5:30 p.m. Mon–Fri

*After hours and Emergency: ORTHOPAEDIC HOSPITAL
2400 S. Flower
Los Angeles, Calif. 90007
Telephone: (213) 742-1000

Division 6 – 100 Sunset Avenue, Venice, Calif.

*REISS-WOZNAK MEDICAL
1908 Santa Monica Blvd.
Santa Monica, Calif. 90404
Telephone: (213) 828-5571
Hours: 7:00 a.m. to 6:00 p.m. Mon–Fri

*VENICE CULVER
12095 Washington Blvd.
Los Angeles, Calif. 90066
Telephone: (213) 391-5241
Hours: 8:00 a.m. to 5:00 p.m. Mon–Fri

*After hours and Emergency: WASHINGTON HOSPITAL
12101 W. Washington Blvd.
Culver City, Calif.
Telephone: (213) 391-0601

Division 7– 8800 Santa Monica Blvd., West Hollywood, Calif.

*CITIZENS MEDICAL
1300 N. LaBrea
Los Angeles, Calif. 90028
Telephone: (213) 464-1336
Hours: 7:30 a.m. to 7:30 p.m. Mon–Fri
9:00 a.m. to 5:00 p.m. Saturday

*BALDWIN HILLS MEDICAL
5753 Rodeo Road
Los Angeles, Calif. 90016
Telephone: (213) 857-1144
Hours: 9:00 a.m. to 9:00 p.m. Mon–Sat

*After hours and Emergency: MIDWAY HOSPITAL
5925 San Vicente
Los Angeles, Calif. 90019
Telephone: (213) 938-3161

Division 8 – 9201 Canoga Avenue, Canoga Park, Calif.

*NORTH VALLEY EMERGENCY MEDICAL CENTER
10324 Mason Avenue
Chatsworth, Calif. 91311
Telephone: (818) 998-6533
Hours: 7:00 a.m. to 11:00 p.m. Mon–Sat

*VALLEY MEDICAL INDUSTRIAL CENTER
8660 Woodley
Sepulveda, Calif. 91343
Telephone: (818) 891-5741
Hours: 7:30 a.m. to 1:00 a.m. Mon–Fri
9:00 a.m. to 5:00 p.m. Saturday

*After hours and Emergency: CANOGA PARK HOSPITAL
20800 Sherman Way
Canoga Park, Calif. 91306
Telephone: (818) 348-0200

Division 9 – 3449 Santa Anita Avenue, El Monte, Calif.

*DALTON MEDICAL
10414 Bacco Street
South El Monte, Calif. 91733
Telephone: (818) 443-3163
Hours: 7:00 a.m. to 11:00 p.m. Mon–Fri
9:00 a.m. to 2:00 p.m. Saturday

*FOOTHILL INDUSTRIAL
1824 Business Center Drive
Duarte, Calif. 91010
Telephone: (818) 359-4541
Hours: 7:00 a.m. to 12:00 p.m. Mon–Fri
7:30 a.m. to 3:30 p.m. Saturday

*TRI CITY INDUSTRIAL MEDICAL GROUP
15438 E. Valley Blvd.
City of Industry, Calif. 91746
Telephone: (818) 968-0736
Hours: 7:00 a.m. Monday thru 2:00 p.m. Saturday

*After hours and Emergency: QUEEN OF THE VALLEY HOSPITAL
1115 S. Sunset
West Covina, Calif. 91790
Telephone: (818) 962-4011

Division 10 – 742 N. Mission, Los Angeles, Calif.

*NORTH MAIN MEDICAL
1744 N. Main Street
Los Angeles, Calif. 90031
Telephone: (213) 225-2261
Hours: 8:00 a.m. to 6:00 p.m. Mon–Fri
9:00 a.m. to 4:00 p.m. Saturday

TEMPLE MEDICAL
124 N. Vignes Street
Los Angeles, Calif. 90012
Telephone: (213) 626-5679
Hours: 24 hours – 7 days

*After hours and Emergency: HOSPITAL OF THE GOOD SAMARITAN
616 South Witmer
Los Angeles, Calif. 90017
Telephone: (213) 977-2121

Division 12 – 970 West Chester Place, Long Beach, Calif.

LONG BEACH MEDICAL CLINIC
757 Pacific Avenue
Long Beach, Calif. 90813
Telephone: (213) 437-0831
Hours: 24 hours – 7 days

*LONG BEACH OCCUPATIONAL MEDICAL CENTER
1447 Santa Fe
Long Beach, Calif.
Telephone: (213) 491-1080
Hours: 7:00 a.m. to 5:00 p.m. Mon–Fri

*After hours and Emergency: ST. MARY'S HOSPITAL
1050 Linden
Long Beach, Calif. 90801
Telephone: (213) 491-9000

Division 14 – 361 East 55th Street, Los Angeles & Vernon Yards, Calif.

PARK PLACE MEDICAL CENTER
3400 E. Florence Avenue
Huntington Park, Calif. 90255
Telephone: (213) 582-8425
Hours: 24 hours – 7 days

*CENTRAL INDUSTRIAL MEDICAL CLINIC
5970 Central Avenue
Los Angeles, Calif. 90001
Telephone: (213) 233-3377
Hours: 7:30 a.m. to 5:30 p.m.

*After hours and Emergency: ORTHOPAEDIC HOSPITAL
2400 S. Flower
Los Angeles, Calif. 90007
Telephone: (213) 742-1000

Division 15 – 11900 Branford, Sun Valley, Calif.

VALLEY MEDICAL INDUSTRIAL
8660 Woodley Avenue
Sepulveda, Calif. 91343
Telephone: (818) 891-5741
Hours: 7:30 a.m. to 1:00 p.m. Mon–Fri
9:00 a.m. to 5:00 p.m. Saturday

*PANORAMA PROFESSIONAL MEDICAL GROUP
9561 Van Nuys Blvd.
Panorama City, Calif. 91402
Telephone: (818) 892-4301
Hours: 7:00 a.m. to 7:00 p.m. Mon–Fri
9:00 a.m. to 12:00 p.m. Saturday

*After hours and Emergency: VALLEY PRESBYTERIAN
15107 Vanowen
Van Nuys, Calif. 91405
Telephone: (818) 782-6600

Division 16 – 1551 E. Mission, Pomona, Calif.

*CENTRAL AVENUE URGENT CARE
8891 Central Avenue
Montclair, Calif. 91763
Telephone: (714) 625-4848
Hours: 8:00 a.m. to 8:00 p.m. Mon–Sat

*READYCARE MEDICAL
2720 N. Garey Avenue
Pomona, Calif. 91767
Telephone: (714) 596-7811
Hours: 8:00 a.m. to 10:00 p.m. Mon–Sat

*After hours and Emergency: POMONA VALLEY COMMUNITY HOSPITAL
1798 N. Garey Avenue
Pomona, Calif.
Telephone: (714) 623-8715

Division 18 – 777 West 190th Street, Gardena, Calif.

*ARTESIA MEDICAL
2499 S. Wilmington Avenue
Compton, Calif. 90220
Telephone: (213) 638-1113
Hours: 24 hours – Mon–Fri

*EMERGENCY MEDICAL GROUP OF TORRANCE
19000 Hawthorne Blvd.
Torrance, Calif.
Telephone: (213) 542-6982
Hours: 8:00 a.m. to 12 midnight Mon–Sun

*After hours and Emergency: COMMUNITY HOSPITAL OF GARDENA
1244 W. 155th
Gardena, Calif. 90247
Telephone: (213) 323-5330

HEADQUARTERS: 425 S. Main Street, Los Angeles, Calif.

TEMPLE MEDICAL GROUP
124 N. Vignes Street
Los Angeles, Calif. 90012
Telephone: (213) 626-5679
Hours: 24 hours – 7 days

*SHELTON LIVINGSTON
1401 S. Hope, No. 202
Los Angeles, Calif. 90015
Telephone: (213) 749-2321
Hours: 7:00 a.m. to 10:00 p.m. Mon–Fri
9:00 a.m. to 4:00 p.m. Saturday

*After hours and Emergency: ORTHOPAEDIC HOSPITAL
2400 S. Flower
Los Angeles, Calif. 90007
Telephone: (213) 742-1000

4. EMERGENCIES: SPECIAL INFORMATION

An EMERGENCY is an unexpected happening, demanding IMMEDIATE ACTION. It is the Supervisor's responsibility to advise EVERY employee in the work unit what to do in a medical emergency. The Supervisor who is present when an employee becomes seriously ill/injured is authorized to arrange emergency medical treatment. IF THE SUPERVISOR IS ABSENT *OR* INJURED, ANY WORKER CAN ARRANGE EMERGENCY MEDICAL TREATMENT. The Supervisor or worker is then directed to:

a. CALL the Dispatch Center, Ext. 6111, if there is any doubt, the employee should be moved and they will arrange for an ambulance; or

b. TRANSPORT employee to nearest emergency medical facility if the employee is able to move or be moved.

c. CONTACT employee's family and provide assistance to the family.

In case of emergency, there may not be time to prepare a Medical Service Order/Return-to-Work Form No. 64-4. The Supervisor should call the physician to authorize the necessary treatment.

C. MEDICAL TREATMENT: FOLLOW-UP CARE

Follow-up medical treatment is provide by the doctor who maintains contact with and/or re-examines the patient at prescribed intervals following the INITIAL medical diagnosis or treatment.

1. EMPLOYEES OWN PHYSICIAN

State law requires an employer to provide all medical treatment necessary to cure and relieve an employee from the effects of an on-the-job injury. There are two exceptions:

a. If the employee notifies his employer in writing prior to being injured of his desire to go to his own doctor in the event of an injury. The doctor designated by the employee must have records on file of having previously treated him/her. If an employee gives you this written notice, it should be put in the personnel file for reference if (s)he is subsequently injured.

b. Thirty (30) days after the date of a work-related injury, the employee may elect to go to a physician of his choice. If an employee informs you of his decision to change physicians, notify *LJR Insurance Services* immediately to avoid any delay in benefits.

D. RECURRENCES

When an employee reports (s)he is unable to work due to a "recurrence" of a previous occupational injury, they should be told that it is their responsibility to provide medical verification that their ab-

sence is due to the prior injury. If they do not provide the verification, their absence will be listed on their personnel records as an illness.

1. AUTHORIZING TREATMENT

The employee should call *LJR* for authorization to see the doctor who treated him/her for the prior injury.

a. If the employee goes to the treating doctor on his own and doctor's office calls you, refer the doctor to *LJR* to authorize the treatment.

b. If the employee does not want to go to the doctor because (s)he feels (s)he needs only one day off work, it is still their responsibility to prove that the absence is due to an occupational injury, and the District is willing to pay for that examination.

c. If the employee wants to go to his own doctor, (s)he should be told that they have that right, but if their doctor was not the treating doctor for the prior injury, this will not provide the necessary verification that their absence was due to the occupational injury.

d. There will be cases where the employee is willing to go to the doctor for the verification, however, *LJR* will not authorize the doctors visit. The case may be closed with no award for further medical treatment, or the injury date may be beyond the statute of limitations and therefore, we would not want to authorize treatment because it would reopen the claim. *LJR* will notify you of these circumstances when they arise and will advise you what they have instructed the employee to do.

2. EMPLOYEE-EMPLOYER'S REPORT

A new report of the injury is not required for a recurrence. However, if it turns out that the absence is actually due to a new injury and not a "recurrence", a report will then have to be completed.

3. POSTING PERSONNEL RECORDS

To enable us to have an accurate record of the absences that are verified as occupational, as well as those that are not:

a. The daily event sheet, or whatever record is kept at the time the employee reports (s)he will be absent should indicate that the employee reported the absence as occupational.

b. Post the absence on the 3IR as an "0" in red pencil.

c. Trace over the "0" in blue or black ink when the employee provides the required medical verification.

d. Enter an "A" in blue or black ink in the center of the red "0" if the employee does not provide the medical verification.

E. TEMPORARY DISABILITY AND RETURN TO WORK

When a doctor certifies that an employee is unable to work because of a work-related illness/injury, (s)he is considered to be temporarily disabled. A disabled employee is entitled to compensation payments known as Temporary Disability for all lost time (time lost from work).

1. TEMPORARY DISABILITY

During the period an employee is temporarily disabled, the Supervisor is to:

a. Plan to talk with the employee at regular pre-determined intervals during the period of temporary disability. Contact can be made by either a visit to the employee's home or a phone call.

b. Request the employee to advise the Supervisor of the approximate date of recovery and when return to work is anticipated.

c. If the employee is requesting sick leave, instruct him/her to obtain written medical authorization from the doctor for all lost time, as sick leave is paid only when medically authorized. (Transportation Department would use form 32-3, Maintenance Department form 22-115. Personnel also has a form 38-97 "Attending Physician's Statement").

2. RETURN TO WORK

Written medical authorization for return to work is required in all cases resulting in lost time.

A doctor's written release provides medical certification that an employee has recovered sufficiently from the illness/injury to return to work. The doctor will also indicate what, if any, medical restrictions from certain activities are necessary. Prior to an employee's actual return to work, the Supervisor shall:

a. Inform the employee that the following is required:
   —A doctor's release with specific reference to the employee's ability to assume job activities.
   —Authorization from *LJR Insurance Services* or the Workers' Compensation Section where there is a question of employee's doctor's release.

b. The Medical Service Order/Return-to-Work Form No. 64-4 given to the employee at the time of injury may be his/her Return-to-Work slip. All medical facilities on our panel have a supply of these forms. The doctor should review the job duties with the employee and sign the Return-to-Work portion on the bottom. This form should be brought in by all employees attempting to return to work, the only exceptions would be those employees referred to a specialist, or who have been authorized to receive treatment from their own physicians. In those cases, RTD Form No. 38-97 "Attending Physicians Statement"

may be used as a release to return to work.

NOTE: If time or geographic location does not permit the employee to immediately bring the release to the Supervisor, the employee may first contact the Supervisor by phone to inform him that he is able to return to work. The employee must then bring the release at the time (s)he reports for work.

c. Phone *LJR Insurance Services* as soon as the employee notifies the Supervisor that a doctor's release to return-to-work has been obtained so that we avoid overpayments of temporary disability.

F. PERMANENT DISABILITY

Permanent Disability is a handicap resulting from the effects of the illness/injury. This means that the employee may return to work with medical restrictions (i.e., no repeated lifting over fifty pounds). Restrictions are guidelines prescribed by a doctor relative to limiting an employee's job activities.

Information regarding medical restrictions appear on the Medical Service Order/Return-to-Work form no. 64-4. In addition, the Workers' Compensation Section will review the medical restrictions with the Supervisor.

The Supervisor is responsible for:

1. Ensuring that the employee is not assigned tasks that are in conflict with the medical restrictions.
2. Instructing the Leader or Unit Supervisor of the employee's medical restrictions.
3. Monitoring the return-to-work performance of the employee. The Personnel Director is available to assist the Supervisor with problems regarding changes in assignment or staffing needs. Please call the Workers' Compensation Section, Extension 6664 regarding questions or problems.

G. MODIFIED WORK

The District has a Special Assistants Program which provides modified work for those injured employees temporarily disabled who are released for work with temporary work restrictions.

The Supervisor will be advised of these medical restrictions by the treating physician who will complete the bottom of the Medical Service Order/Return-to-Work Form No. 64-4. The placing of these employees into the available Special Assistant positions will be coordinated by the Visiting Nurse.

H. REHABILITATION

If the medical restrictions placed on an injured employee are permanent and would not allow the employee to return to his regular occupation, we are required by State law to provide rehabilitation. The decision as to whether the employee qualifies for rehabilitation is made by the Workers'

Conpensation Claims Administrator based on their medical file.

I. DENTAL CARE

If a work-related accident results in trauma that requires dental treatment, the Supervisor shall arrange for the necessary treatment as follows:

1. Contact *LJR Insurance Services* for referral to a dentist as necessary.
2. Record the name, address, and phone number of the treating dentist on the Employer's Report (Form No. 64-1).
3. Instruct employee to remind the dentist that prior to treatment, authorization from the District's Workers' Compensation Administrator must be obtained.
4. Authorize examination by providing the employee with the Medical Service Order/Return-to-Work Form No. 64-4.

J. QUESTIONABLE CLAIMS

If at any time during a work-related injury claim you discover information that leads you to question the validity of the claim, notify *LJR Insurance Services.* Also, contact the doctor on our panel prior to an employee's first visit if you have information that might help the doctor to determine the validity of the claim. On those cases when the employee does not immediately report the claim or injury, follow the normal reporting procedures for handling the claim when they do report it. In addition, instruct the employee to complete in his own handwriting a chronological statement describing what has happened relative to his injury since it occurred, including:

1. Why the accident was not reported earlier.
2. What medical treatment (x-rays, laboratory tests, etc.) has been received including names and addresses of doctors or medical clinics.

The Employer's Report form no. 64-1, the above signed statement, and any other information the Supervisor may have regarding the alleged accident should be sent promptly to *LJR Insurance Services.* If the employee has already been treated by his own doctor, advise him that treatment by an unautorized physician may not be reimbursed.

Provide the employee with the name and address of the appropriate clinic on our approved list. Contact the doctor before the employee arrives for examination to inform the doctor he should report on the nature of the injury. Do not authorize follow-up treatment. Then inform *LJR Insurance Services* of the case. They will determine if treatment is to be authorized.

K. INSURANCE DEPARTMENT ASSISTANCE

The Insurance Department should be notified by calling the Workers' Compensation Representative on Extension 6664 immediately following a serious or unusual work-related injury such as:

1. Those involving hospitalization of the employee at the outset.
2. Those caused by unprovoked attack.
3. Those involving a delayed report by the injured employee.
4. Any other questionable or unusual claim.

L. INQUIRIES

Any inquiries or correspondence directed to the District regarding a work-related injury case should be referred to *LJR Insurance Services.* In no case should any information be released concerning a work-related injury without their prior approval.

INDEX

SAFE-4
REV 10/84

SOUTHERN CALIFORNIA RAPID TRANSIT DISTRICT

SAMPLE

MEDICAL SERVICE ORDER
RETURN TO WORK FORM

(Write firmly – you are making 4 copies)

TIME IN:	
TIME OUT:	
DATE:	

Risk Management Department
425 South Main Street
Los Angeles, California 90013

MEDICAL TREATMENT AUTHORIZATION

EMPLOYEE NAME	BADGE NO.	DATE OF INJURY
THELMA A. TYPIST	7798	4-6-85
SUPERVISOR'S SIGNATURE	**TITLE**	**DATE**
Sam A. Supervisor	Manager	4-6-85
DEPARTMENT/DIVISION	**ADDRESS**	**TELEPHONE**
INSURANCE, 7400	425 S. MAIN ST. L.A.	972-6662

ATTENDING PHYSICIAN INSTRUCTIONS

The Southern California Rapid Transit District provides modified work assignments for employees with work-related, temporary disabilities for up to 90 days. These employees are assigned to various departments during their temporary disability, and are not returned to their usual work duties. Due to the varied work activities of the District, there is usually some type of employment which can be found to meet an injured employee's medical limitations.

Please consider the availability of this modified work before making a decision on our employee's estimated period of disability.

Please complete the items on the form below and return it with employee. Please note that this form does not replace the physician's first report of work injury. Complete form after every employee treatment/visit and distribute copies appropriately.

If you have any questions regarding modified work assignments, please call LJR Insurance Services, Inc., Claims Administrator, at 642-1148 or 216-6996, or write to P.O. Box 92387, Los Angeles, California 90009. For questions concerning R.T.D.'s Worker's Compensation Program, call 972-6664. For questions concerning safety matters, call 972-6545.

INJURY STATUS REPORT – TO BE COMPLETED AFTER EVERY VISIT

EMPLOYEE WORK STATUS

☐ Return to regular work
Date _____

☐ Unable to return to work
until _____

☐ Modified work
until _____
(Complete section below)

MODIFIED WORK AS INDICATED BELOW

☐ 1. No prolonged standing or walking

☐ 2. No climbing, bending or stooping

☐ 3. No prolonged sitting

☐ 4. No driving: ☐ Bus ☐ Car

☐ 5. No work near moving machinery

☐ 6. Weight lifting restriction:
- ☐ 0-15 pounds
- ☐ 15-35 pounds
- ☐ 35-50 pounds

☐ 7. Range of motion restriction:
_____

☐ 8. Will patient be required to take medication(s) when returned to work? If YES, please indicate type of medication and any special work precautions related to the use of this medication:
_____
_____

☐ 9. Other _____

DOCTOR'S DIAGNOSIS AND COMMENTS: (IMPORTANT: Please also indicate AFTER EVERY EMPLOYEE VISIT the type, length and expected duration of treatment.) _____

_____

☐ Next appointment Date _____
☐ Injury requires no further treatment; discharged as cured, no permanent disability.

PHYSICIAN'S NAME (Please print or type) _____ SIGNATURE _____ DATE _____

ADDRESS _____ TELEPHONE _____

1 Original - LJR Insurance Services 2 Yellow - Division Supervisor 3 Pink - RTD Safety Department 4 Goldenrod - Physician

SAFE-1
REV 3/85

STATE OF CALIFORNIA

EMPLOYEE — EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TO BE FILLED OUT BY THE INJURED EMPLOYEE WHENEVER POSSIBLE WITHIN 12 HOURS OF THE INJURY

EMPLOYER

1. RTD
2. Southern California Rapid Transit District, 425 South Main Street, Los Angeles, CA 90013
3. (213) 972-6000
4. Lawfully Uninsured
5. UI # 910-0525

WRITE FIRMLY - YOU ARE MAKING THREE COPIES

FORWARD ORIGINAL & FIRST COPY TO:
LJR Insurance Services, Inc.
P. O. Box 92387
Los Angeles, CA 90009
(213) 216-6996

OSHA CASE NO.: 85 - 7400 - 2 (YEAR) (DEPT NO.) (NO.)

PLEASE DO NOT USE THIS COLUMN

EMPLOYEE

6 NAME: TYPIST (LAST) THELMA (FIRST) A. (MI)
7. BADGE NUMBER: 7798
8 SOCIAL SECURITY NUMBER: 541-26-3475
9 HOME ADDRESS (number and street, city, zip): 3241 SPRUCE ST. PASADENA 93416
10. HOME PHONE NUMBER: (818) 446-3147
11 SEX: ☐ Male ☒ Female
12. OCCUPATION (regular job title, not specific activity at time of injury): CLERK TYPIST
13 DATE OF BIRTH: AGE 23 — 3 (Month) / 21 (Day) / 62 (Year)
14 DEPARTMENT IN WHICH REGULARLY EMPLOYED: 7400 (NUMBER) INSURANCE (NAME)
15. PAYROLL STATUS: ☒ FULL TIME ☐ PART TIME
16 AVG. NO. OF HRS WORKED PER WK: 40
17. DATE OF HIRE: 5 (Month) / 19 (Day) / 82 (Year)
18. WAGES: $ 8.76 ☐ Per month ☐ Per week ☒ Per hour
19. HEIGHT: 5' 2"
20. WEIGHT: 110
21 MARITAL STATUS: SINGLE
22. DRIVERS LICENSE NO: D 347631
23. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (address, city): 425 S. MAIN ST. LOS ANGELES
County: LOS ANGELES
24. ON EMPLOYER PREMISES? ☒ YES ☐ NO
25 WHAT WERE YOU DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material you were using.)
WALKING UPSTAIRS FROM 3RD FLOOR CAFETERIA WITH MY LUNCH.
26. If RTD vehicle involved, give equipt. No.

INJURY OR ILLNESS

27 HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)
CAUGHT MY FOOT ON EDGE OF STEP, FELL FORWARD STRIKING MY RIGHT KNEE ON STEPS + DROPPED TRAY OF FOOD, SPILLING HOT COFFEE ON MY LEFT HAND.

28 OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in cases of strains, the thing he was lifting, pulling, etc.)
STEPS + SPILLED COFFEE

29 NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED
BRUISED RIGHT KNEE + BURN ON LEFT HAND

30. NAME AND ADDRESS OF PHYSICIAN: TEMPLE MEDICAL 124 N. VIGNES
31. IF HOSPITALIZED, NAME OF HOSPITAL
☐ BED PATIENT ☐ EMERGENCY ONLY
32 DATE OF INJURY OR ILLNESS: 4 (Month) / 6 (Day) / 85 (Year)
33 TIME OF DAY: ___ a.m. 12:25 p.m.
34 SIGN-ON TIME: 8 a.m. ___ p.m.
35. DID YOU LOSE AT LEAST ONE FULL DAY'S WORK AFTER THE INJURY? ☒ No ☐ Yes, date last worked ___
36 WITNESS NAME: SALLY SECRETARY
37. ADDRESS: PERSONNEL DEPT
38. TELEPHONE NO.: 6200
39 WAS ANOTHER PERSON RESPONSIBLE FOR YOUR INJURY OR ILLNESS? IF SO, GIVE NAME, ADDRESS, TELEPHONE, DRIVERS LICENSE
NO
40 COULD YOU OR YOUR SUPERVISOR HAVE DONE ANYTHING TO PREVENT INJURY? IF SO PLEASE EXPLAIN.
NO
41. DATE INJURY REPORTED TO SUPERVISOR: 4-6-85
42. TIME: 12:30 ☐ A.M ☒ PM
43 ARE YOU ENGAGED IN ANY OTHER TYPE OF WORK, EMPLOYMENT OR ENTERPRISE? YES ☐ NO ☒ IF "YES," ON A SEPARATE SHEET STATE NAME AND ADDRESS OF EMPLOYERS, TYPE OF WORK, POSITION AND DATE LAST WORKED
44. • EMPLOYEE'S STATEMENT: I certify that all statements in this report are true, and I agree and understand that any misstatement or omission of a material fact herein may constitute cause for dismissal.
• I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION REGARDING THIS INJURY OR ILLNESS TO REPRESENTATIVES OF MY EMPLOYER
Thelma A. Typist — EMPLOYEE'S SIGNATURE — 4/6/85 DATE

SUPERVISOR

45. HAS EMPLOYEE RETURNED TO WORK? ☐ No, still off work ☒ Yes, date returned 4-6-85
46. DID EMPLOYEE DIE? ☒ No ☐ Yes, date ___
47. DATES OF OCCUPATIONAL INJURY OR ILLNESS DURING PAST THREE YEARS (Mo/Yr/Body Part): NONE
48 IN YOUR JUDGEMENT, COULD YOU OR THE EMPLOYEE HAVE DONE ANYTHING TO PREVENT INJURY? EXPLAIN YOUR ANSWER
YES, USE ELEVATORS WHEN CARRYING FOOD
49. WAS ACCIDENT PREVENTABLE? YES ☒ NO ☐
• SUPERVISOR'S STATEMENT: I CERTIFY THAT I HAVE THOROUGHLY INVESTIGATED THIS INCIDENT AND THAT THE INFORMATION AS REPORTED IS COMPLETE AND CORRECT. IF NOT, ATTACH SHEET WITH EXPLANATION.

Sam G. Supervisor	7648	Manager	6662	4/6/85
SIGNATURE OF SUPERVISOR	BADGE NO.	TITLE	TELEPHONE	DATE

ORIGINAL — LJR Insurance Serv.
YELLOW — LJR Insurance Serv.
PINK — Safety Department
GOLDENROD — Employee Personnel File

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

(STATE FORM 5020)

CASE NO. | EMPLOYER NO | INDUSTRY | SEX | AGE | OCCUPATION | WEEKLY WAGE | COUNTY | ACCIDENT TYPE | AGENCY | AGENCY PART | SUPPLEMENTAL AGENCY | NATURE OF INJURY | PART OF BODY | INJURY DATE | EXTENT OF INJURY | INSURANCE CARRIER | REPORT LAG | CODED BY | LOST TIME | MEDICAL | INFORMATION | SUBROGATION | RESERVE

SAFE-1
REV 3/85

STATE OF CALIFORNIA

EMPLOYEE — EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TO BE FILLED OUT BY THE INJURED EMPLOYEE WHENEVER POSSIBLE WITHIN 12 HOURS OF THE INJURY.

EMPLOYER

1. RTD
2. Southern California Rapid Transit District, 425 South Main Street, Los Angeles, CA 90013
3. (213) 972-6000
5. Lawfully Uninsured
   U I # 910-0525

WRITE FIRMLY - YOU ARE MAKING THREE COPIES

FORWARD ORIGINAL & FIRST COPY TO:
LJR Insurance Services, Inc.
P. O Box 92387
[illegible], CA 90009
(213) 216-6996

OSHA CASE NO.: -3200-1

(DEPT NO.) (INCI.)

PLEASE DO NOT USE THIS COLUMN

EMPLOYEE

6. NAME: OPERATOR (LAST), OLIVER (FIRST) T. (MI)
7. BADGE NUMBER: 11534
8. SOCIAL SECURITY NUMBER: 517-64-5613
9. HOME ADDRESS (number and street, city zip): 5715 OAK ST. LOS ANGELES 90043
10. HOME PHONE NUMBER: (213) 665-1436
11. SEX: [X] Male [ ] Female
12. OCCUPATION (regular job title, not specific activity at time of injury): BUS DRIVER
13. DATE OF BIRTH: 4 / 15 / 57 (Month / Day / Year) AGE 28
14. DEPARTMENT IN WHICH REGULARLY EMPLOYED: 3200 (NUMBER) TRANS (NAME)
15. PAYROLL STATUS: [X] FULL TIME [ ] PART TIME
16. AVG NO OF HRS WORKED PER WK: 45
17. DATE OF HIRE: 10 / 23 / 81 (Month / Day / Year)
18. WAGES: $ 13.00 [ ] Per month [ ] Per week [X] Per hour
19. HEIGHT: 5' 11"
20. WEIGHT: 175
21. MARITAL STATUS: MARRIED
22. DRIVERS LICENSE NO: D 3474?9

INJURY OR ILLNESS

23. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (address, city): 4TH + BROADWAY
County:
24. ON EMPLOYER PREMISES? [ ] YES [X] NO
25. WHAT WERE YOU DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material you were using.): PULLING INTO FAR SIDE STOP ON BROADWAY NORTH OF 4TH STREET
26. If RTD vehicle involved, give equipt No: 8849
27. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.): CAR REARENDED BUS PULLING INTO BUS ZONE. I WAS THROWN OUT OF SEAT + STRUCK MY HEAD ON FAREBOX
28. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in cases of strains, the thing he was lifting, pulling, etc.): FAREBOX
29. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED: CUT ON HEAD + BRUISED RIGHT SHOULDER
30. NAME AND ADDRESS OF PHYSICIAN: TEMPLE MEDICAL, 124 N. VIGNES
31. IF HOSPITALIZED, NAME OF HOSPITAL: CALIFORNIA HOSPITAL
[X] BED PATIENT [ ] EMERGENCY ONLY
32. DATE OF INJURY OR ILLNESS: 4 / 23 / 85 (Month / Day / Year)
33. TIME OF DAY: 10 a.m. ____ p.m.
34. SIGN-ON TIME: 7 20 a.m. ____ p.m.
35. DID YOU LOSE AT LEAST ONE FULL DAY'S WORK AFTER THE INJURY? [ ] No [X] Yes, date last worked 4-23-85
36. WITNESS NAME: MARY JONES
37. ADDRESS: 1643 MAPLE AVE L. A.
38. TELEPHONE NO: 443-2176
39. WAS ANOTHER PERSON RESPONSIBLE FOR YOUR INJURY OR ILLNESS? IF SO, GIVE NAME, ADDRESS, TELEPHONE, DRIVERS LICENSE: JOHN BROWN 6341 LA BREA INGLEWOOD 674-2613 D 479263
40. COULD YOU OR YOUR SUPERVISOR HAVE DONE ANYTHING TO PREVENT INJURY? IF SO, PLEASE EXPLAIN: NO
41. DATE INJURY REPORTED TO SUPERVISOR: 4-23-85
42. TIME: 10 [X] AM [ ] PM
43. ARE YOU ENGAGED IN ANY OTHER TYPE OF WORK, EMPLOYMENT OR ENTERPRISE? YES [ ] NO [X]
IF "YES," ON A SEPARATE SHEET STATE NAME AND ADDRESS OF EMPLOYERS, TYPE OF WORK, POSITION AND DATE LAST WORKED
44. • EMPLOYEE'S STATEMENT: I certify that all statements in this report are true, and I agree and understand that any misstatement or omission of a material fact herein may constitute cause for dismissal.
• I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION REGARDING THIS INJURY OR ILLNESS TO REPRESENTATIVES OF MY EMPLOYER
Oliver T. Operator — EMPLOYEE'S SIGNATURE — 4/25/85 DATE

SUPERVISOR

45. HAS EMPLOYEE RETURNED TO WORK? [X] No, still off work [ ] Yes, date returned
46. DID EMPLOYEE DIE? [X] No [ ] Yes, date
47. DATES OF OCCUPATIONAL INJURY OR ILLNESS DURING PAST THREE YEARS (Mo/Yr/Body Part): 6/24/82 BACK; 10/16/84 LEG
48. IN YOUR JUDGEMENT, COULD YOU OR THE EMPLOYEE HAVE DONE ANYTHING TO PREVENT INJURY? EXPLAIN YOUR ANSWER: NO
49. WAS ACCIDENT PREVENTABLE? YES [ ] NO [X]
• SUPERVISOR'S STATEMENT: I CERTIFY THAT I HAVE THOROUGHLY INVESTIGATED THIS INCIDENT AND THAT THE INFORMATION AS REPORTED IS COMPLETE AND CORRECT. IF NOT, ATTACH SHEET WITH EXPLANATION

SIGNATURE OF SUPERVISOR	BADGE NO.	TITLE	TELEPHONE	DATE
Michael Manager	7643	Div. Manager	6000	4/25/85

ORIGINAL — LJR Insurance Serv.
YELLOW — LJR Insurance Serv.
PINK — Safety Department
GOLDENROD — Employee Personnel File

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

(STATE FORM 5020)

CASE NO
EMPLOYER NO.
INDUSTRY
SEX
AGE
OCCUPATION
WEEKLY WAGE
COUNTY
ACCIDENT TYPE
AGENCY
AGENCY PART
SUPPLEMENTAL AGENCY
NATURE OF INJURY
PART OF BODY
INJURY DATE
EXTENT OF INJURY
INSURANCE CARRIER
REPORT LAG
CODED BY
LOST TIME
MEDICAL
INFORMATION
SUBROGATION
RESERVE

ACCIDENT REPORT

SOUTHERN CALIFORNIA RAPID TRANSIT DISTRICT	DATE OF ACCIDENT	TIME A.M. P.M.	DIVISION NO.	REPORT NO.

DENT ON _____ STREET (AT) (BETWEEN) _____

CITY _____ STATE _____

NAME OF EMPLOYEE _____ BADGE NO. _____ DATE EMPLOYED _____ AGE _____

CO. VEH. NO. _____ TYPE _____ (ST. CAR: BUS: ETC.) LINE NO. _____ (INDICATE IF EXPRESS) BUS RUN NO. _____

GEN. DIRECTION (EASTBOUND ETC.) _____ BOUND. WEATHER _____ CONDITION OF STREET _____

IN SERVICE _____ OUT OF SERVICE _____ DAY OFF _____ REG. WORK DAY _____ REG. OPER. _____ EX. BOARD _____

BUS _____ ON TIME ___/___ MIN. LATE ___ NO OF PASSENGERS _____ NO OF COURTESY CARDS OBTAINED _____

DESCRIPTION OF ACCIDENT: FOR ADDITIONAL INFORMATION USE EXTRA REPORT FORM.

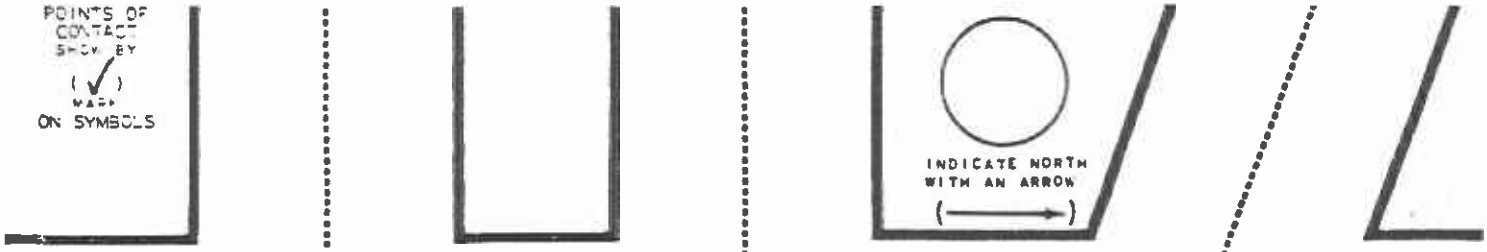
SUMMARY AS TO TYPE OF ACCIDENT: _____

DESCRIBE THE ACCIDENT (OR INCIDENT) IN DETAIL: _____

DATE OF REPORT _____ EMPLOYEE'S SIGNATURE _____ (INDICATE CLASSIFICATION) OPERATOR ☐ STUDENT ☐ OTHER ☐

GRAPHIC DIAGRAM: IMPORTANT (DRAW COMPLETE DIAGRAM OF WHERE, AND HOW, ACCIDENT HAPPENED USING SYMBOLS BELOW. SHOWING STREET NAMES AND INDICATING DIRECTION OF TRAVEL BY LINE OF ARROWS OF VEHICLES INVOLVED.)

ILLUSTRATION — CO. VEH. — OTHER VEHICLE — PEDESTRIAN



LOCAL OFFICE USE ONLY					
ACC. TYPE	VEH. CODE	DPR. RESP.	CONTEST		

CLAIM DEPT. USE ONLY				
FIELD	LINE	YR	NUMBER	SUFFIX

REPORT CHECKED (LOCAL OFFICE)

BY:

DISPR. NOTIFIED

BY:

TIME ON DUTY

HRS. ____ MINS. ____

RTD 32-43
REV 4/73

PERSONS INVOLVED OR INJURED

WERE POLICE AT SCENE OF ACCIDENT? YES_____NO_____OFFICER'S BADGES_____

OFFICER'S NAMES_____

NAMES	STREET	CITY	PHONE NO.	APPARENT INJURIES	PASSENGER	PEDESTRIAN	OTHER VEH.	APPROX. AGE	RACE
1									
2									
3									
4									
5									
6									

IF AMBULANCE/DOCTOR CALLED (NAME)_____ BY WHOM CALLED? _____

FIRST AID:_____

WHAT MEDICAL TREATMENT GIVEN: NAME OF HOSPITAL _____

HOSPITALIZED:_____

TRAFFIC ACCIDENT (Vehicle, Pedestrian, Etc.)

OTHER VEHICLE OR PROPERTY: (FOR ADDITIONAL INFORMATION, USE EXTRA REPORT FORM)

OWNER_____
NAME STREET CITY PHONE NO.

DRIVER_____
NAME STREET CITY PHONE NO.

VEH. LICENSE NO._____ MAKE & TYPE OF VEHICLE _____ DRIVER'S LICENSE NO. _____

DAMAGE TO VEHICLE OR PROPERTY_____

DIRECTION OF OTHER VEHICLE _____

NO. OF PERSONS IN VEHICLE _____

WAS OTHER VEHICLE INSURED? YES_____NO_____ NAME OF COMPANY_____

EST. SPEED WHEN FIRST NOTICED_____M.P.H.; AT TIME OF COLLISION_____M.P.H.; DIST. TRAVELED AFTER COLLISION_____FT.

COMPANY VEHICLE: HOW FAR WERE YOU FROM POINT OF ACCIDENT WHEN YOU NOTICED DANGER? _____FT.

EST. SPEED WHEN YOU FIRST NOTICED DANGER_____M.P.H.; HOW FAR FROM COLLISION WHEN YOU APPLIED BRAKES?_____FT.

EST. SPEED OF YOUR VEHICLE AT TIME OF COLLISION_____M.P.H.; HOW FAR DID YOUR VEHICLE MOVE AFTER COLLISION?_____FT.

DAMAGE TO CO. VEH._____

REPORTED BY: (PRINT) (SIGN)

ADDR_____

PASSENGER ACCIDENT

AT TIME OF ACCIDENT: (CHECK PROPER ITEMS) WAS PERSON: BOARDING____ ALIGHTING_____ ON BOARD_____ AT FRONT DOOR _____

AT REAR DOOR_____ STRUCK BY DOORS_____TYPE OF DOOR CONTROL (MANUAL_____TREADLE_____OTHER_____)

MOTION OF CO. VEHICLE: STANDING_____ STARTING_____STOPPING_____ RUNNING (STRAIGHT_____ CURVE_____) GOING_____ M.P.H.

IF A FALL, GIVE LOCATION: FRONT STEPS__FRONT PLATFORM__AISLE__REAR OR CENTER PLATFORM__REAR OR CENTER STEPS_____

DID PERSON CONTACT CO. VEH. IN FALLING? YES____NO_____; IF OUTSIDE, DISTANCE FROM VEHICLE _____FT.

DISTANCE OF DOOR INVOLVED FROM CURB_____FT._____

MISC. INCIDENT

(DISTURBANCES, ARRESTS, EJECTMENTS, FITS, SICKNESS, FALLS NOT ON COMPANY VEHICLE, OTHER COLLISIONS, ETC.)

DID INCIDENT OCCUR ON CO. VEHICLE? YES_____NO_____; IF NOT, GIVE DISTANCE FROM COMPANY VEHICLE _____FT.

WAS PERSON A PASSENGER PRIOR TO INCIDENT? YES_____NO_____; WAS COMPANY VEHICLE INVOLVED? YES_____NO_____.

CONDITION EQUIPMENT

DID YOU NOTICE ANY EQUIPMENT DEFECTS (STEPS, FLOORS, DOORS, SEATS, BRAKES, ETC.? YES_____NO_____.

DESCRIBE DEFECTS _____

WHOM DID YOU NOTIFY OF DEFECTS?_____WHEN?_____

RTD 32-3
REV. 11-76
SOUTHERN CALIFORNIA RAPID
TRANSIT DISTRICT

SOUTHERN CALIFORNIA RAPID TRANSIT DISTRICT

REQUEST FOR SICK LEAVE PAY / RELEASE TO DUTY

ORIGINAL — ACCOUNTING
YELLOW — P/R FILE
PINK — PAY FILE

DEPT. NO.	BADGE NO.	EMPLOYEE NAME (LAST NAME · FIRST NAME)	SENIORITY DATE
			— —

TO BE ELIGIBLE FOR SICK LEAVE BENEFITS – THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE'S ATTENDING PHYSICIAN AND SUBMITTED BY THE EMPLOYEE TO HIS DIVISION OFFICE NO LATER THAN 20 DAYS AFTER HIS RETURN TO WORK. BY SUBMISSION OF THIS FORM I HEREBY CLAIM ALL ENTITLED SICK LEAVE PAY.

EMPLOYEE SIGNATURE	REQUEST DATE
	— —

NATURE OF ILLNESS/INJURY:

WAS EMPLOYEE HOSPITALIZED: YES ☐ NO ☐

NAME OF HOSPITAL: _____

DATES OF TREATMENT: _____ _____ _____ _____

DATES HOSPITALIZED: FROM _____ TO _____

ATTENDING PHYSICIAN (OFFICE INFO)

NAME: _____

ADDRESS: _____

OFFICE PHONE: _____

DATE RELEASED FOR DUTY: _____

ATTENDING PHYSICIANS SIGNATURE

SCRTD – OFFICE USE ONLY

LAST DATE WORKED	DAYS OFF (AS OF LAST DAY WORKED)	DATE RETURNED TO WORK	DATE FORM RECEIVED	RECEIVED BY
— —	—	— —	— —	— —

CLAIM DATES (MONTH, DAY, YEAR)	NUMBER OF DAYS (1)	COLUMN (1) X 8 HOURS (2)	SUBJECT TO SDI INTEGRATION: S.D.I. CHART (3)	SUBJECT TO SDI INTEGRATION: AMOUNT PAID (Col. 2 Minus Col. 3)
		:	:	:
		:	:	:
		:	:	:
			TOTAL (Hours & Minutes)	:

DEPARTMENT TIMEKEEPER SIGNATURE	SICK BANK BEG. BAL. (HOURS & MINUTES)	CHARGED TO SICK BANK (HOURS & MINUTES)	PAY RATE	DATE PAID
	:	:	.	— —

DEPARTMENT AUTHORIZED SIGNATURE	PAYROLL PERIOD ENDING	CONTROL ACCOUNTING AUDIT
	— —	

ACCOUNTING

PERS-97
REV 9/84

SOUTHERN CALIFORNIA RAPID TRANSIT DISTRICT
425 SOUTH MAIN STREET, LOS ANGELES, CALIFORNIA 90013
PERSONNEL DEPARTMENT • (213)972-6225

ATTENDING PHYSICIAN'S STATEMENT

Name of Employee	Dept./Div.	Badge	Telephone

Home Address	City	State	Zip Code

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Patient's Signature _____ Date _____

1. Diagnosis and concurrent conditions

2. Is condition due to injury or sickness arising out of patient's employment?
☐ Yes ☐ No

Pregnancy?
☐ Yes ☐ No EDC _____

3. Report of services

Date of Services	Description of surgical or medical services rendered

4. Date symptoms first appeared or date of injury

5. Will diagnosis be reported to the DMV?
☐ Yes ☐ No

6. Will diagnosis be reported to our Worker's Compensation Carrier?
☐ Yes ☐ No

7. Patient still under your care for this condition?
☐ Yes ☐ No

8. This employee may:

___ Climb stairs, ladders
___ Drive heavy equipment
___ Drive to and from work
___ Other _____
___ Be exposed to chemicals or fumes
___ Perform repeated heavy lifting
___ Operate machinery
___ Repeatedly bend, stoop, twist
___ Sit for prolonged periods
___ Stand for prolonged periods

9. If still disabled, approximate date patient should be able to return to work

10. Patient is able to return to regular work on _____ Date
☐ With no restrictions ☐ With the following restrictions:

ADDITIONAL COMMENTS:

11. Will patient be required to take medication(s) when returned to work? ☐ Yes ☐ No
If YES, will those medications restrict employee's regular work? ☐ Yes ☐ No

Date _____ Physician's Name (Print) _____ Signature _____ Degree _____

Street Address _____ City or Town _____ State or Province _____ Zip Code _____ Telephone _____