Alum Rock Union Elementary School District

Bloodborne Pathogens Exposure Control Plan

Regulation: CCR-Title n8, Section 5193

Program last updated: **July 1, 2018**

Scope: The Exposure Control Plan (ECP) applies to all employees with actual or potential exposure to bloodborne pathogens at all sites.

Policy Statement

It is the policy of the Alum Rock Union Elementary School District to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with federal and state regulations. All human blood and other potentially infectious materials will be treated as if known to be infectious for human immunodeficiency virus (HIV), Hepatitis B virus (HBV), and other bloodborne pathogens.

Plan Administration

Table 1 provides the roles and contact information for the administration of the bloodborne pathogens program.

Table 1
Program Contact Information

Task	Name/Department	Phone
Plan Administrator	Carlos Moran, Director, Human Resources	Work: (408) 928-6503
Supplies (PPE, cleaning materials, other)	Jacalyn Stromquist, Human Resources Ed Villarreal, M&O	Work: (408) 928-6504 Work: (408) 928-6872
Medical recordkeeping	Jacalyn Stromquist, Human Resources	Work: (408) 928-6504
Training	Carlos Moran, Human Resources Site Administrators/ Program Managers Jacalyn Stromquist, Human Resources	Work: (408) 928-6503 Work: Refer to AR directory Work: (408) 928-6504
Exposure incident contact	Jacalyn Stromquist, Human Resources	Work: (408) 928-6504

The ECP administrator is responsible for implementation of the ECP, and will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures and to reflect new or revised employee positions with occupational exposure.

Ed Villarreal will provide and maintain all necessary PPE, engineering controls (e.g., sharps containers), and labels as required by the standard, and will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.

Jacalyn Stromquist will be responsible for ensuring that all medical actions required by the standard are performed and that appropriate employee health and OSHA records are maintained.

Carlos Moran, site administrators and program managers will be responsible for training, documentation of training, and making the written ECP available to employees, the regulating authority, and representatives of the California Occupational Safety and Health Association (CalOSHA).

Jacalyn Stromquist will act as the initial contact for reporting exposure incidents and ensure that the appropriate response is carried out.

Those employees determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this ECP.

Annual Plan Review and Update
This ECP will be reviewed and updated annually, and whenever new hazards are introduced in the workplace or conditions change that would result in a change in occupational exposure by employees.

Access to the ECP
Employees covered by the bloodborne pathogens rules and policies will receive an explanation of this ECP during their initial training session. It will also be reviewed in their annual refresher training. All employees can review this plan at any time during their work shifts by contacting the Administrative Assistant. A copy of the ECP will be provided free of charge to any employee who requests it. A copy of the ECP can also be found on the AR intranet under Department Resources.

Definitions

Universal precaution—an approach to infection control whereas all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Bloodborne pathogen—microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) which causes acquired immune deficiency syndrome (AIDS).

Exposure incident—a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral (i.e., needlestick) contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Occupational exposure—reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. "Good Samaritan" acts such as assisting a co-worker with a nosebleed are not considered occupational exposure.

Other potentially infectious materials (OPIM)—body fluids visibly contaminated with blood, including saliva in dental procedures, semen, vaginal secretions, amniotic fluid, and other such material where it is difficult to differentiate between body fluids.

Percutaneous injury— exposure by injection or absorption through the unbroken skin.

Personal protective equipment (PPE)—protective covering for the head, eyes, hands, feet, and body, such as nitrile or other liquid-resistant gloves, a face mask, or an apron.

Sharps—any object contaminated with blood or OPIM that can penetrate the skin, including needles, scalpels, wood or metal splinters, broken glass, broken capillary tubes, and exposed ends of dental wires.

Employee Exposure Determination

Determinations for employee exposure are made for at risk job classifications where occupational exposure to blood or OPIM occurs, is likely to occur, or is possible to occur.

Table 2 contains a list of all job classifications in which employees are at high risk of or likely to have occupational exposure to bloodborne pathogens.

Table 2
Likely Occupational Exposure—Job Classifications

Job Classification	Department/ Work Area	Exposure Task/Procedure
Bus Driver	Transportation	Student contact
Custodian	M&O	Cleaning up after students, assist in first aide
Health Assistant	Student Services	Administering first aide
Nurse	Student Services	Administering first aide and injections
Infant Care Paraeducator	Student Services	Student contact, toileting
Special Education Paraprofessional	Special Education	Student contact, toileting
Special Education Teacher	Special Education	Student contact

Table 3 contains a list of job classifications in which employees may at some time have occupational exposure, including part-time, temporary, contract, or per diem employees. The list includes tasks and procedures, or groups of closely related tasks and procedures, for which occupational exposure may occur for these individuals.

Table 3
Possible Occupational Exposure—Job Classifications

Job Classification	Department/ Work Area	Exposure Task/Procedure
School Administrative Assistants	Site	Administering first aide
School Clerical Office Assistants	Site	Administering first aide

If an employee believes that he or she may be occupationally exposed to bloodborne pathogens and his or her job classification or tasks do not appear on the above lists, the employee should contact Carlos Moran, Human Resources.

Implementation and Control Measures

Universal Precautions

All employees will use universal precautions in order to prevent contact with blood or OPIM. All blood and OPIM will be considered infectious regardless of the perceived status of the source.

Engineering Controls and Work Practices

Engineering controls and work practices will be implemented to prevent or minimize exposure to bloodborne pathogens. Carlos Moran is responsible for ensuring that the engineering controls and work practices are implemented and updated as necessary.

The following engineering controls will or have been implemented:

- PPEs distributed
- New employee orientation training
- Annual review training
- Update Bloodborne Pathogen Exposure Control Plan annually and published on intranet
- Periodic information articles published
- Postings at all sites

The following work practices will be followed:

- Wash hands immediately after contact with blood or OPIM.
- Exposed employees will wash their hands with running water and soap as soon as possible after using the antiseptic alternatives.
- When skin or mucous membranes are exposed to blood or OPIM, those areas of the body will be washed or flushed with running water as soon as possible after contact.
- After removal of PPE (e.g., gloves, face mask) used during exposure to blood or OPIM, the employee(s) will wash hands or other exposed skin areas with running water and soap as soon as possible.

Carlos Moran evaluates new exposure control procedures and new products regularly by reviewing the Safety Data Sheets (SDS) and consulting with Student Services and Maintenance and Operations.

Housekeeping—Cleaning and Decontamination

All equipment, work areas, and working surfaces will be cleaned and decontaminated immediately or as soon as possible after any spill of blood or OPIM materials, after completion of procedures, and at the end of the work shift if the surface may have become contaminated since the last cleaning.

Decontamination of surfaces, equipment, and work areas will be accomplished by using the following materials:

- **3M Quat Disinfectant Cleaner; Product #5 Twist n' Fill**

Blood- or OPIM-contaminated waste will be placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded, and closed prior to removal to prevent spillage or protrusion of contents during handling.

The procedure for handling sharps disposal containers is:

1. Notify M&O for pick up.
2. M&O disposes in the hazardous waste container.
3. M&O calls for hazardous waste pick up from:
    - Photo Waste Recycling CO, Inc.
    - 2980 Kerner Blvd. #C
    - San Rafael, CA 94901-5588

The procedure for handling blood- or OPIM-contaminated waste is:

1. Dispose of hazardous waste in a designated bag.
2. Notify M&O for pick up.
3. M&O disposes in the hazardous waste container.
4. M&O calls for hazardous waste pick up from a designated company.

Contaminated sharps will be discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak proof on sides and bottoms, and appropriately labeled or color-coded. Clean sharps disposal containers are available at site Health office.

Bins, pails (e.g., wash or emesis basins), cans, and similar receptacles will be inspected and decontaminated on a regularly scheduled basis, and cleaned and decontaminated as soon as possible after visible contamination.

Broken glassware that may be contaminated will only be picked up using mechanical means, such as a brush and dustpan.

Sharps Injury Prevention

The following sharps safer devices and engineering controls will be implemented:

- Needleless IV system
- Self-sheathing

All employees will comply with the following work practice controls to reduce exposure to sharps:

- Contaminated needles and other contaminated sharps will not be bent, recapped, or removed.
- Shearing or breaking contaminated needles is prohibited.
- Contaminated reusable sharps must be placed in designated reusable sharps containers.
- Any bending, recapping, or needle removal must be handled by the school nurse.

Sharps disposal. Sharps disposal containers are inspected and maintained or replaced by the school nurse whenever necessary to prevent overfilling.

Review and update procedures. This facility identifies the need for changes in engineering controls and work practices for the management of sharps through:

- Review of OSHA records
- Interviews with employees responsible for direct patient care

Carlos Moran evaluates new procedures and new products regularly by reviewing new state and federal requirements and student needs.

Both front-line workers and management officials are involved in the process for evaluating new procedures and products in the following manner:

Union input
State and Federal guidelines
District needs

Student Services is responsible for ensuring that approved procedures are implemented.

PPE

PPE is provided to our employees at no cost to them. PPE will be chosen based on the anticipated exposure to blood or OPIM. The PPE will be considered appropriate only if it does not permit blood or OPIM to pass through or reach the employee's clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which it will be used.

Table 4 describes in detail how PPE will be provided and the types of PPE that will be given to employees.

Table 4
Provision of PPE to Employees

How Provided	PPE Distributor	Procedures Requiring PPE	Type of PPE Required
M&O Department	Ed Villarreal	Cleaning	Gloves, glasses, clothing
Health Services	Erika Marcos	Cleaning and first aide	Gloves
Training	Carlos Moran Site Administrator Program Managers	Cleaning and first aide	Gloves
Site Staff	Site Administrators	Cleaning and first aide	Gloves

All PPE will be cleaned, laundered, and disposed of by the employer. All repairs and replacements will be made by the employer.

All PPE will be removed prior to leaving the work area. If visibly contaminated, PPE will be placed in an appropriately designated area or container for storage, washing, decontamination, or disposal. The designated area is the custodial closet.

Precautions when using PPE. All employees using PPE must observe the following precautions:

- Wash hands immediately or as soon as possible after removal of gloves or other PPE.
- Remove PPE after it becomes contaminated, and before leaving the work area.
- Used PPE may be disposed of in the hazardous waste container.
- Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised.
- Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.

- Never wash or decontaminate disposable gloves for reuse.
- Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
- Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.

Blood-contaminated PPE
If PPE or personal clothing is splashed or soaked with blood or OPIM, the person wearing the PPE or clothing will remove the contaminated clothing as soon as possible. This clothing will be laundered at the employer's expense. Such clothing will be identified as contaminated and any employee exposed to it will be notified and protected from exposure.

Gloves
Gloves will be worn where it is reasonably anticipated that employees will have hand contact with blood, OPIM, non-intact skin, and mucous membranes. Gloves will be available from Ed Villarreal, health assistants, and site administrators.

Disposable gloves will not be washed or decontaminated for reuse and will be replaced when they are torn, punctured, or when their ability to function as a barrier is compromised. Utility gloves may be decontaminated for reuse provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

PPE Training
All employees covered under the requirements of this Plan will be trained to properly use, put on, take off, decontaminate, maintain, and store PPE. Training in the use of the appropriate PPE is provided by Ed Villarreal, Carlos Moran and site administrators.

Disposable PPE
Disposable gloves and paper face masks must not be used again once they are removed. Never wash or decontaminate disposable gloves for reuse. Replace them as soon as possible after they become contaminated or if they are torn, punctured, or their ability to function as a barrier is compromised.

Disposable PPE may be discarded in the regular trash if it has no visible contamination with blood or OPIM. Place PPE with visible contamination with blood or OPIM in a sharps or biohazard container.

Hepatitis B Vaccination
Carlos Moran and site administrators will provide training to employees on hepatitis B vaccinations, addressing safety, benefits, efficacy, methods of administration, and availability.

The hepatitis B vaccination series is available at no cost after initial employee training and within 10 days of initial assignment to all employees identified in the exposure determination section of this ECP.

When an employee elects to be vaccinated, a licensed health care professional will conduct a medical evaluation.

Vaccination is encouraged unless:

- Documentation exists that the employee has previously received the series;
- Antibody testing reveals that the employee is immune; or
- Medical evaluation shows that vaccination is contraindicated.

Following the medical evaluation, a copy of the health care professional's written opinion will be obtained and provided to the employee within 15 days of the completion of the evaluation. The evaluation will be limited to whether the employee requires the hepatitis vaccine and whether the vaccine was administered.

Vaccination will be provided by Kaiser if the employee is a Kaiser member or US Healthworks or Alliance Occupational Medicine for all other employees.

Declination of the vaccine. If an employee declines the vaccination, the employee must sign a declination form (attached to this ECP). Employees who decline may request and obtain the vaccination at a later date at no cost. Signed declination forms are kept in Human Resources.

Exposure Incident Management

Exposure Incident Report

Any incident that results in occupational exposure to blood or OPIM will be reported immediately to Jacalyn Stromquist. A separate report must be completed by each person exposed to blood or OPIM. The report will include the name of the person exposed, the time and date of the incident, and a determination of whether an exposure has occurred. If exposure has occurred, a post-exposure evaluation will be performed.

See Attachment 3 for a copy of the Incident Report form.

Post-Exposure Evaluation and Follow-up

A confidential medical evaluation and follow-up will be conducted by one of the clinics listed below. After initial first aid or medical attention; the following activities will be performed by:

US Healthworks **1717 South Main Street** **Milpitas, CA** **(408) 957-5700**	**OR**	**Alliance Occupational Medicine** **315 South Abbott Avenue** **Milpitas, CA** **(408) 790-2900**

- Document the routes of exposure and how the exposure occurred.
- Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).
- Obtain consent and make arrangements to have the source individual tested as soon as possible to determine HIV, HCV, and HBV infectivity; document that the source individual's test results were conveyed to the employee's healthcare provider.
- If the source individual is already known to be HIV, HCV and/or HBV positive, new testing need not be performed.
- Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).
- After obtaining consent, collect exposed employee's blood as soon as feasible after exposure incident, and test blood for HBV and HIV serological status.

If the employee does not give consent for HIV serological testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days. If the exposed employee elects to have the baseline sample tested during this waiting period, perform testing as soon as feasible.

Administration of Post-Exposure Evaluation and Follow-up

Jacalyn Stromquist ensures that the healthcare professional(s) responsible for employee's hepatitis B vaccination and post-exposure evaluation and follow-up are given a copy of the bloodborne pathogens regulation. Jacalyn Stromquist will ensure that the healthcare professional evaluating an employee after an exposure incident receives:

- A description of the employee's job duties relevant to the exposure incident
- A description of route(s) of exposure
- Circumstances of exposure
- If possible, results of the source individual's blood test
- Relevant employee medical records, including vaccination status

US Healthworks or Alliance will provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days after completion of the evaluation.

Procedures for Evaluating the Circumstances Surrounding an Exposure Incident
Carlos Moran will review the circumstances of all exposure incidents to determine the:

- Engineering controls in use at the time
- Work practices followed
- Description of the device being used (including type and brand)
- Protective equipment or clothing that was used at the time of the exposure incident (gloves, eye shields, etc.)
- Location of the incident
- Procedure or task being performed when the incident occurred
- Employee's training

Student Services Department and Jacalyn Stromquist will record all percutaneous injuries from contaminated sharps in a Sharps Injury Log.

Employee Training

All employees who have occupational exposure to bloodborne pathogens will receive initial and annual training conducted by Carlos Moran and/or site administrator/Program Manager.

All employees who have occupational exposure to bloodborne pathogens will receive training on the epidemiology, symptoms, and transmission of bloodborne pathogen diseases. In addition, the training program covers, at a minimum, the following elements:

- A copy and explanation of the OSHA bloodborne pathogen standard
- An explanation of our ECP and how to obtain a copy
- An explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
- An explanation of the use and limitations of engineering controls, work practices, and PPE
- An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
- An explanation of the basis for PPE selection
- Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine will be offered free of charge
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
- An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
- Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident
- An explanation of the signs and labels and/or color coding required by the standard and used at this facility
- An opportunity for interactive questions and answers with the person conducting the training session

Training materials for this facility are available at the front office and/or AR intranet.

Recordkeeping

Training Records
Training records are completed for each employee upon completion of training. These documents will be kept for at least 3 years in Risk Management.
The training records will include the:

- Dates of the training sessions
- Contents or a summary of the training sessions
- Names and persons conducting the training
- Names and job titles of all persons attending the training sessions

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to Jacalyn Stromquist.

Medical Records
Medical records are maintained for each employee with occupational exposure in accordance with the employee exposure and medical records regulation. Jacalyn Stromquist is responsible for maintenance of the required medical records. These confidential records are kept in Risk Management for at least the duration of employment plus 30 years.

OSHA Recordkeeping
An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by Jacalyn Stromquist.

Sharps Injury Log
In addition to the OSHA recordkeeping requirements, all percutaneous injuries from contaminated sharps are also recorded in a Sharps Injury Log. All incidents will include at least:

- The date of the injury
- The type and brand of the device involved (syringe, suture needle)
- The department or work area where the incident occurred
- An explanation of how the incident occurred

The Sharps Injury Log is reviewed as part of the annual program evaluation and maintained for at least 5 years following the end of the calendar year covered. If a copy is requested by anyone, it will have any personal identifiers removed from the report.

Supporting Materials

Attachment 1 Hepatitis B Vaccine Declination Form
Attachment 2 Refusal of Post-Exposure Medical Evaluation
Attachment 3 Exposure Incident Report
Attachment 4 Procedures for completing required Workers' Compensation paperwork
Attachment 5 Form 5020
Attachment 6 Form DWC
Attachment 7 Report of Employee Work Related Injury or Illness form
Attachment 8 Waiver of Medical Attention
Attachment 9 US Healthworks Milpitas location
Attachment 10 Alliance Occupational Medicine Milpitas location
Attachment 11 Student Bloodborne Pathogen Exposure and Major Incident Report Form
Attachment 12 Training Record for the Bloodborne Pathogens Exposure Control Program
Attachment 13 Bloodborne Pathogens Annual Checklist for Administrators
Attachment 14 Verification form

HEPATITIS B VACCINE CONSENT/DECLINATION

Name _____ ARUESD ID#_____

Job Classification _____ Location _____

Hepatitis B virus (HBV) is a major cause of viral hepatitis. Its most common method of transmission is from the blood of acutely or chronically infected people. Health care workers are at increased risk of HBV infection because of contact with blood products. The serious complications and results of HBV infection include liver damage, cirrhosis of the liver, chronic active hepatitis, cancer of the liver and death. Between 6% and 10% of young adults with HBV infection become carriers of hepatitis B virus. Chronic active hepatitis develops in over 25% of such carriers and often progresses to cirrhosis of the liver. Hepatitis B elated liver cancer is developed by 4% of carriers. There is no specific treatment for hepatitis B infection.

The hepatitis B virus vaccine is 80%-95% effective in preventing hepatitis in susceptible people. The vaccine is given intramuscularly in three doses, with the second and third doses given one and six months after the first dose. Recombinant hepatitis B vaccine is contraindicated in the presence of hypersensitivity to yeast or any component of the vaccine. The most common side effect has been limited to soreness or redness at the injection site. Systemic complaints could include fatigue/weakness, fever, headache, and malaise. Because of the long incubation period of hepatitis B, it is possible for unrecognized infection to be present at the time the vaccine is given and vaccination may not prevent hepatitis B in these cases. The duration of protection is probably more than five years but this, or the need for boosters, is yet to be determined.

I, the undersigned, have read the above and understand the risks and benefits of the hepatitis B vaccine. I have had the opportunity to have my questions answered satisfactorily.

PLEASE CHECK: [ ] I request that the hepatitis B vaccine be administered to me.

KAISER INSURED: YES [ ] NO [ ]

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

[ ] I presently decline the hepatitis B vaccine.

[ ] I have already had the hepatitis B vaccine. Year received_____.

DATE **EMPLOYEE** NAME (PRINT) SIGNATURE

DATE **WITNESS** NAME (PRINT) SIGNATURE

REFUSAL OF POST-EXPOSURE MEDICAL EVALUATION

I am employed by the Alum Rock Union Elementary School District and have received training regarding infection control and the risk of disease transmission.

On (date) _____, I was involved in an exposure incident. The District offered to provide follow-up medical evaluation for me in order to assure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, I, of my own free will and despite my employer's offer, have elected not to have a medical evaluation for personal reasons.

_____

Print Name

_____

Employee Signature

_____

ARUESD ID Number

_____

Employer Representative

_____

Date

Please Send to Risk Management/Human Resources

JS7/1/2018

Bloodborne Pathogens Exposure Incident Report

Employee Instructions
You are completing this form because you have experienced an actual or a potential exposure to blood or other potentially infectious material. An evaluation of this exposure is required by regulation.

Please complete all the information below. Take this form with you when you go to a physician or other healthcare provider for the evaluation of the exposure. The information contained on this form is crucial to a proper evaluation of the exposure. Please take the time and care in completing the form to insure that the information is clear and accurate. If you need information on where to have this medical evaluation performed, please contact your supervisor.

The medical evaluation for a suspected exposure to blood or other potentially infectious material should be done *as soon as possible* after the exposure. The effectiveness of certain vaccines or other medication which might prevent any illness resulting from these exposures is greatest if given shortly after the exposure.

Complete the appropriate accident report for your supervisor.

Employee's Statement: (Please Print)

Name: _____

Job Title: _____ Work Location: _____

Work Phone: _____ Supervisor: _____

Description of Exposure Incident

Date: _____ Time: _____ am / pm

City/Town: _____ State: _____

Describe Incident (Please include the type of infectious material to which you were exposed and the circumstances of the exposure):

_____

_____

_____

_____

_____

_____

_____

_____

Supervisor's Statement: (Please Print)

Employee's Name: _____

Supervisor Identification.

Name: _____

Work Phone: _____

Description of Incident
(Please describe the employee's duties as they relate to the exposure incident):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Hepatitis B Status
The employee named above has / has not (circle one) received a three dose series of hepatitis B Vaccine. If yes, the series was completed on _____ (date).

Investigation of Source
Please describe what information is known about the source of the exposure (the person's name, address, telephone number, or other contact point), the result(s) of the blood testing of the source person (if known), or why blood testing of the source person is not feasible. Also, if the source person is known to have or test positive for hepatitis B or human immunodeficiency virus (HIV), please indicate this fact. The source person must be tested for these agents unless such testing is not legally possible.

_____

_____

_____

_____

_____

_____

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

PROCEDURE FOR FILLING OUT AND FILING WORK RELATED INJURY FORMS

REPORT OF EMPLOYEE WORK RELATED INJURY OR ILLNESS

The **supervisor/office staff designee** completes this form with the employee. The employee and **supervisor/office staff designee** must sign this form.

DWC-1

The Labor Code requires that the employee/injured worker be given a claim form DWC 1 within 24 hours of knowledge of a work related injury. In some cases, as in emergencies and/or a call in injury, this may not be possible. The recommendation is that the form be completed per #1 below and the form sent to the employee/injured worker via certified mail. When the form is returned, # 3 below should be followed.

There is nothing in the Labor Code that requires an employee to return the form; however, it is in the employee's best interest to do so.

1. Once the **supervisor/office staff designee** has knowledge of a work related and/or potential injury, numbers 9, 10, 11, 12, 14, 15, 16 and 17 should be completed **prior** to the form being given to the employee. (**NOTE:** 13. should be left blank)

2. It is the **employee/injured worker's** responsibility to complete the top portion, numbers 1, 2, 3, 4, 5, 6, 7 and 8 and return the form to the supervisor/office staff designee in a timely manner.

3. Once the supervisor/office staff designee receives the completed form from the employee, number 13 should be completed by the **supervisor/office staff designee** and a **copy** of the completed form should be given to the employee/injured worker.

5020 (EMPLOYER'S REPORT)

The entire 5020 form must be completed by the employee/injured worker's **supervisor/office staff designee.** The employee **DOES NOT** fill out any portion of this form.

FILING PROCESS

Once a **supervisor/office staff designee** has knowledge of a work related and/or potential injury he/she must immediately notify **(CALL)** the Risk Management Office and submit the completed required **three** forms to the Risk Management Office within **24 hours** of the injury.

MEDICAL WAIVER FORM

If the employee does not wish to seek medical attention for a work related injury; the employee must complete this form in addition to the above mentioned forms.

MEDICAL TREATMENT-If the injured worker does not have a physician designation form on file prior to the work related injury; he/she **MUST** seek medical attention at one of the following Occupational Medical Clinics:

US Healthworks 1717 South Main Street Milpitas, CA 95035
OR
Alliance Occupational Medicine 315 South Abbott Avenue Milpitas, CA 95035

IN CASE OF AN EMERGENCY
EMPLOYEE IS TO GO TO REGIONAL HOSPITAL FOR TREATMENT

ATTACHED ARE SAMPLES OF COMPLETED FORMS.

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

REPORT OF EMPLOYEE WORK RELATED INJURY OR ILLNESS

✓ EMPLOYEE ___ OTHER

Name Alex Anders Social Security No 555-55-5555

Home Address 222 Holly Ct. San Jose, CA 95127 Phone 408 922-2222

Date of Birth 2/22/80 Occupation Teacher Date of Injury 9/10/18

School/Dept. DO Salary: Hourly___ Daily___ Weekly___ Monthly 880

10-month X 11-month___ 12-month___ Hours/day 6.75 Hours/week 33.75 Date of Hire 8/21/15

Nature of injury of illness Sprain (cut, strain, etc.) Part of body affected Left Knee (back, left wrist, eye, etc.)

Did employee see a doctor? ✓ Yes ___ No

Name and Phone Number of physician Alliance 408-790-7900

Address of physician 315 S. Abbott Ave Milpitas, CA 95035

Where did accident or exposure occur? DO (school, department, other)

Location Board Room On district property? ✓ Yes ___ No

How did accident or exposure occur? (Please describe fully the events that resulted in injury or occupation disease. Tell what and how it happened and what the employee was doing. Please use a separate sheet if necessary. Include the names of other employees, machinery, equipment, tools, etc., involved).

Emp was walking across room; tripped & fell on left knee.

What unsafe act, equipment, or condition caused injury? none

What unsafe condition exists as a result of the accident? none

Did employee lose at least one full day's work after the injury? ✓ No __Yes-Date last worked ___ (mo/day/yr)

Witness: ___ No ✓ Yes -- Please provide name, address, phone number, employer, etc. of witness room full of people

If injury was caused by another person or circumstances, provide name, address, phone police report, etc. n/A

What type of personal protective equipment was being worn? n/A

What corrective action has been taken, or will be taken, to prevent a recurrence? n/A

Alex Anders — Employee's Signature

9/10/18 — Date report Completed

Max Maxwell — Supervisor's Signature

This report is to be completed during the work shift the injury occurs.
If employee leaves work, a MEDICAL RELEASE IS REQUIRED BEFORE RETURNING

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: ARUSD
1a. Policy Number:
2. MAILING ADDRESS (Number, Street, City, Zip): 2930 Gay Ave. San Jose, CA 95127
2a. Phone Number: 4089286800
3. LOCATION if different from Mailing Address (Number, Street, City, and Zip):
3a. Location Code:
4. NATURE OF BUSINESS: e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Public School District
5. State unemployment insurance acct. no.:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

Please do not use this Column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm / dd / yy): 10/18
8. TIME INJURY/ILLNESS OCCURRED: ____ AM 12 PM
9. TIME EMPLOYEE BEGAN WORK: 8 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm / dd / yy): N/A
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☒ No
12. DATE LAST WORKED (mm / dd / yy): N/A
13. DATE RETURNED TO WORK (mm / dd / yy): N/A
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☒ Yes ☐ No
16. SALARY BEING CONTINUED? ☒ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm / dd / yy): 10/18
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy): 10/18
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
Nature of Injury: Sprain
Parts of Body: left knee
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 2930 Gay Ave 95127
20a. COUNTY: Santa Clara
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop: Board Room
23. Other Workers Injured/Ill in this event? ☐ Yes ☒ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: none
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck: Walking across room & tripped
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
Emp. states he walking across the room, tripped and fell on his left knee
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip): Alliance 315 S. Abbott, Milpitas, CA 95035
27a. Phone Number: 408 9902800
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☒ No ☐ Yes If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip):
28a. Phone Number: ( )
29. Employee treated in Emergency Room? ☐ Yes ☒ No

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

EMPLOYEE

30. EMPLOYEE NAME: Alex Anders
31. SOCIAL SECURITY NUMBER: 555-55-5555
32. DATE OF BIRTH (mm / dd / yy): 2/22/80
33. HOME ADDRESS (Number, Street, City, Zip): 222 Holly Ct. San Jose 95127
33a. PHONE NUMBER: 408-922-2222
34. SEX: ☒ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Teacher
36. DATE OF HIRE (mm / dd / yy): 8/2/15
37. EMPLOYEE USUALLY WORKS: 6.75 hours per day, 5 days per week, 33.75 total weekly hours
37a. EMPLOYMENT STATUS: ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY: $500 per month
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): Max Maxwell 4089281111
Signature & Title: Max Maxwell - Principal
Date (mm / dd / yy):

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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.* Alex Anders — Today's Date. *Fecha de Hoy.* 9/10/18
2. Home Address. *Dirección Residencial.* 222 Holly Cx.
3. City. *Ciudad.* San Jose — State. *Estado.* CA — Zip. *Código Postal.* 95127
4. Date of Injury. *Fecha de la lesión (accidente).* 9/10/18 — Time of Injury. *Hora en que ocurrió.* a.m. 12 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* DO 2930 Gay Ave. SJ 95127 Board Room
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Sprained left knee
7. Social Security Number. *Número de Seguro Social del Empleado.* 555-55-5555
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.* Alex Anders

Employer—complete this section and see note below. *Empleador—complete esta sección y note la notación abajo.*

10. Name of employer. *Nombre del empleador.* ARUSD
11. Address. *Dirección.* 2930 Gay Ave. San Jose, CA 95127
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 9/10/18
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 9/10/18
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 9/10/18
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* Tristar PO Box 2805 Clinton, Iowa 52733
16. Insurance Policy Number. *El número de la póliza de Seguro.* VEA2WC000004-00
17. Signature of employer representative. *Firma del representante del empleador.* Max Maxwell
18. Title. *Título.* Principal — 19. Telephone. *Teléfono.* 408-928-1111

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 compañía 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*

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City, Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

DATE OF INJURY
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401.** You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401.** Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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 as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

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. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. 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 compañía 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*

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

REPORT OF EMPLOYEE WORK RELATED INJURY OR ILLNESS

___EMPLOYEE ___OTHER

Name _____ Social Security No._____

Home Address _____ Phone ( ) _____

Date of Birth _____ Occupation_____ Date of Injury _____

School/Dept._____ Salary: Hourly____ Daily____ Weekly____Monthly_____

10-month____ 11-month_____ 12-month____ Hours/day _____ Hours/week_____ Date of Hire_____

Nature of injury of illness_____ Part of body affected_____

(cut, strain, etc.) (back, left wrist, eye, etc.)

Did employee see a doctor? ___Yes ___No

Name and Phone Number of physician_____

Address of physician_____

Where did accident or exposure occur?_____

(school, department, other)

Location_____ On district property? ____Yes ____No

How did accident or exposure occur? (Please describe fully the events that resulted in injury or occupation disease. Tell what and how it happened and what the employee was doing. Please use a separate sheet if necessary. Include the names of other employees, machinery, equipment, tools, etc., involved).

_____

_____

_____

_____

_____

What unsafe act, equipment, or condition caused injury? _____

What unsafe condition exists as a result of the accident? _____

Did employee lose at least one full day's work after the injury? _____No __Yes-Date last worked_____

(mo/day/yr)

Witness: ____No ___Yes -- Please provide name, address, phone number, employer, etc. of witness _____

_____

If injury was caused by another person or circumstances, provide name, address, phone police report, etc. _____

_____

What type of personal protective equipment was being worn?_____

_____

What corrective action has been taken, or will be taken, to prevent a recurrence?_____

_____

_____

Employee's Signature Date report Completed Supervisor's Signature

This report is to be completed during the work shift the injury occurs.
If employee leaves work, a MEDICAL RELEASE IS REQUIRED BEFORE RETURNING

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

WAIVER OF MEDICAL ATTENTION

DATE: _____

EMPLOYEE NAME: _____

SOCIAL SECURITY #: _____

TITLE: _____

WORK LOCATION: _____

TYPE OF INJURY: _____

I understand that as an employee of Alum Rock Union Elementary School District, I am entitled to receive medical attention when I sustain an injury/illness on the job.

I have completed and submitted to ARUESD's Risk Management Department a Report of Employee Work Related Injury or Illness Form, Form 5020 and Form DWC-1.

At this time I do not wish to seek medical attention for the injury/illness I sustained on

_____.

_____

Employee's Signature **Date**

I understand that if I decide to seek medical attention at a later date due to this injury (within one year from the actual injury date), I can be treated at one of the following district authorized medical facilities:

US Healthworks
1717 South Main Street
Milpitas, CA 95035

Alliance Occupational Medicine
315 South Abbott Avenue
Milpitas, CA 95035

NOTE TO ADMINISTRATORS AND/OR ADMINISTRATIVE/OFFICE ASSISTANTS:
This form must be submitted along with the injury report and the workers' compensation form to the Risk Management Office when an employee declines medical attention.

US Healthworks Milpitas-1717 South Main Street Milpitas, CA 95035

Driving directions to US Healthworks from Alum Rock District Office:

1. Take Gay Avenue to N. Capitol Avenue.
2. Make a right onto N. Capitol Avenue.
3. Make a left onto McKee Road; merge onto I-680 North.
4. Take Montague Expressway/Landess Avenue exit; keep left to take Montague Expressway ramp and merge onto Montague Expressway.
5. Turn right onto S. Main Street.
6. US Healthworks is on the left; 1717 S. Main Street.

HOURS OF OPERATION: 8:00 AM – 6:00 PM

Alliance Occupational Medicine Milpitas-315 S. Abbott Ave. Milpitas, CA 95035

Driving directions to Alliance Occupational Medicine from Alum Rock District Office:

1. Take Gay Avenue to N. Capitol Avenue.
2. Make a right onto N. Capitol Avenue.
3. Make a left onto McKee Road; merge onto I-680 North.
4. Take exit toward CA-237/Milpitas.
5. Merge onto E. Calaveras Blvd. via the ramp on the left toward CA-237.
6. Turn left onto S. Abbott Avenue.
7. Alliance Occupational Medicine is on the right; 315 S. Abbott Avenue

HOURS OF OPERATION: 7:00 AM – 7:00 PM

STUDENT BLOODBORNE PATHOGEN EXPOSURE
And
MAJOR INCIDENT REPORT FORM

Name: _____ **School** _____

Date of Incident: _____ **Time:** _____

Potentially Infectious Material(s) Involved: _____

Source: _____

Describe the incident in detail; circumstances, who was involved? Where did it occur? _____

_____

_____

_____

What Personal Protective Equipment (PPE) was used? _____

_____

What action was taken? (decontamination, clean up, reporting, etc.) _____

_____

Recommendations for avoiding repetition: _____

_____

Were parents notified? ( )Yes ( )No By: ( )Writing ( )Phone ( )Other

By Whom? _____ **Date:** _____ **Time:** _____

Other comments: _____

_____

_____

_____
Name of Administrator completing report

JS/7/1/2018

TRAINING RECORD FOR BLOODBORNE PATHOGENS EXPOSURE CONTROL PROGRAM

Name of School/Department_____

Address_____

Date of training session_____

Name and Title of Person conducting training session_____

_____

Summary of training session_____

_____

_____

_____

_____

Name and Title of persons attending training session

Signature	Print Name	Title	Date

NOTE: Maintain this record for three years

Continued on next page

CONTINUED

TRAINING RECORD FOR THE BLOODBORNE PATHOGENS EXPOSURE PROGRAM

Name and Title of persons attending training session

Signature	Print Name	Title	Date

NOTE: Maintain this record for three years

Distribution: Send to Risk Management/Human Resources
Maintain 1 copy at Site/Department

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

BLOODBORNE PATHOGENS
ANNUAL CHECK-LIST FOR ADMINISTRATORS

_____ **"Exposure Control Plan for Bloodborne Pathogens" available for reference at site**

_____ **Schedule Annual review for all employees**
Training DVD
Review Plan

_____ **Office staff trained in Post-Exposure Referral Process**
Incident Report and Employee Rights
Workers' Compensation forms (2) plus map to Clinics
Refusal of Post-Exposure Medical Evaluation form

_____ **Identify special needs on campus**

ALUM ROCK UNION ELEMENTARY SCHOOL DISTRICT

VERIFICATION

I have participated in the Alum Rock Union Elementary School District bloodborne pathogen training on (date) _____, and I certify that I reviewed and understood the material presented.

Name_____
Print

Signature_____

Work Location_____