All work-related injuries and illnesses, regardless of their type of seriousness, must be immediately reported to supervisor and the Associated Student’s Human Resources Office. If the injured party requires emergency medical attention, call 911 or DPS at Extension 3333 or 911. The following procedures should be followed in the event of an injury and/or illness:

**Notify a supervisor or manager immediately.** If the employee works through a temporary employment agency, contact the Executive Assistant.

**Do not attempt to administer first-aid.** Please note that while “Band-Aid Box Injuries,” which includes any one time treatment of minor cuts, scrapes and splinters, may be treated on site, all other injuries should be treated at the Student Health Center or St. Rose Occupational Health Clinic (see attached).

**Complete the Supervisor’s Report of Accident.** Once the supervisor has been notified of an injury, he/she should report to the site and/or injured employee with an “Injury Information Packet” and complete the Supervisor’s Report of Accident. The Injury Information Packet includes the Supervisor’s Report of Accident (booklet), Medical Referral Form (yellow) and directions to authorized treatment centers. Injury information Packets are available at Customer Service and the Associated Student’s Lobby.

…if additional treatment is unnecessary or if the employee refuses medical attention, it should be noted on the report. Distribute report copies as indicated and return any unused Injury Information Packets forms to the Associated Student’s Human Resources Office.

…if additional treatment is needed, instruct the employee to take the Medical Referral Form (see attached) to an authorized treatment center. The supervisor or designee should accompany or transport the injured employee. If the employee is from a temporary agency, he/she will need to go to the agency specified treatment center.

**Submit the Supervisor’s Report of Accident immediately** to the Associated Student’s Human Resources Office. Under no circumstances may an employee return to work without a Visit Verification Slip and/or release notice from the authorized treatment center.

*NOTE: Please notify the Associated Student’s Human Resources Office if additional Injury Information Packets are needed.*
IF THIS IS A MEDICAL EMERGENCY, PLEASE CALL 911 and SEDGWICK CMS IMMEDIATELY.

To Whom This May Concern:

The information provided below will help you in expediting medical reports and insurance claim forms for CSUEB Associated Student's employee work-related injuries:

**Provider of Workers’ Compensation is:**
California State University, East Bay Associated Student’s, Inc.
25976 Carlos Bee Blvd.
Hayward, CA 94542-1699
(510) 885-3501

Contact: Human Resources

**Workers’ Compensation Carrier is:**
Sedgwick CMS
P.O. Box 3170
Rancho Cordova, CA 95741

Contact: Claims Dept.

Please provide the required employee with a visit verification slip. Care providers should forward a copy of the doctor’s first report and related billing to Sedgwick CMS for payment.

**Employee:**
Medical attention is available at CSUEB Student Health Center, x53735, or St. Rose Occupational Health Clinic (O.H.C.), St. Rose Hospital, 27200 Calaroga Ave, (at Tennyson), Hayward, 264-4046. Saint Rose O.H.C. is open Monday through Friday from 7:30am – 5:00pm. It is located on the left side of the driveway as you enter from Calaroga Ave. Parking is available adjacent to the clinic.

You must obtain a visit verification slip from the medical facility before returning to work and submit to the Associated Student's Human Resources or your supervisor immediately. You will not be allowed to work without the physician’s release.
### Directions to St. Rose Hospital (If Student Health Center is closed)

<table>
<thead>
<tr>
<th>Directions</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Est. Time:</strong> 9 minutes <strong>Total Est. Distance:</strong> 4.04 miles</td>
<td></td>
</tr>
<tr>
<td><strong>1:</strong> Start out going WEST on CARLOS BEE BLVD toward HAYWARD BLVD.</td>
<td>0.1 miles</td>
</tr>
<tr>
<td><strong>2:</strong> Turn LEFT to stay on CARLOS BEE BLVD.</td>
<td>0.6 miles</td>
</tr>
<tr>
<td><strong>3:</strong> CARLOS BEE BLVD becomes ORCHARD AVE.</td>
<td>0.5 miles</td>
</tr>
<tr>
<td><strong>4:</strong> Turn RIGHT onto SOTO RD.</td>
<td>0.2 miles</td>
</tr>
<tr>
<td><strong>5:</strong> Turn LEFT onto JACKSON ST / CA-92. Continue to follow CA-92 W.</td>
<td>1.0 miles</td>
</tr>
<tr>
<td><strong>6:</strong> Merge onto I-880 S toward SAN JOSE.</td>
<td>0.9 miles</td>
</tr>
<tr>
<td><strong>7:</strong> Take the TENNYSON ROAD exit.</td>
<td>0.1 miles</td>
</tr>
<tr>
<td><strong>8:</strong> Take the TENNYSON RD WEST ramp.</td>
<td>0.1 miles</td>
</tr>
<tr>
<td><strong>9:</strong> Merge onto W TENNYSON RD.</td>
<td>0.1 miles</td>
</tr>
<tr>
<td><strong>10:</strong> Turn RIGHT onto CALAROGA AVE.</td>
<td>&lt;0.1 miles</td>
</tr>
<tr>
<td><strong>11:</strong> End at St Rose Hospital: 27200 Calaroga Ave, Hayward, CA 94545, US</td>
<td></td>
</tr>
</tbody>
</table>
Work Related Injury Verification Form

This form must be completed by the Human Resources Assistant and submitted to the Human Resources Manager within one week of the incident.

Employee Name: ____________________________ Date of Injury: ____________
Department: ____________________________ Supervisor’s Name: ________________

SECTION I:  

Was a “Supervisor’s Injury/Illness Report” completed?  

Yes     No

Were copies of the report distributed accordingly? (please verify)

☐ Personnel Office (White Copy)
☐ Personnel File (Blue Copy)
☐ Supervisor (Yellow Copy)

Did the Employee receive a copy of the pamphlet “Facts for Injured Workers?”

Was the injury recorded on the Injury Report Log?

Was the employee sent to an authorized treatment center?

If yes, continue to section II. If no, continue to Section IV

SECTION II: Additional treatment for injury

Did the employee return to work?

If yes, Date of return: ____/____/____

Did the employee submit a Visit Verification Slip from the medical facility?

If no, obtain the slip immediately. **DO NOT ALLOW** the employee to continue to work without the physician’s written authorization.

Was a copy of the Doctor’s First Report of Injury forwarded to the Worker’s Compensation carrier?

Did the physician indicate that this was a Worker’s Compensation injury (i.e. beyond first aid care)?

If yes, complete section III. If no, complete section IV.
SECTION III: Worker’s Compensation Injury

Complete if accident is a Worker’s Compensation Related Injury which resulted in lost time beyond date of incident and/or required medical treatment beyond first aid.

Check if completed:

Employee completed the DWC-1 Form and returned it to the Human Resources Office.

Date DWC-1 Form was given to employee: _____/_____/_____
Date DWC-1 Form was returned to the Associated Student’s: _____/_____/_____

The following must be completed within 24 hours of receipt of the DWC-1 from the employee:

Complete the Employer’s section of the DWC-1 Form and provide the employee one copy, keep one copy for Department records, and forward the original and 1 copy to the Human Resources office.

Using the same information as the DWC-1 form, complete Form 5020 and distribute copies as indicated above.

Determine if additional documentation from the manager, supervisor and/or witnesses is needed, attach to the employer’s file copy and submit to the Human Resources office.

SECTION IV:

Employee was not sent to a treatment center because:

_______ additional treatment beyond first aid was not necessary
_______ employee refused additional medical attention

Employee was sent to a treatment center where the physician determined that additional treatment beyond first aid:

_______ was not needed
_______ will be needed

Additional Remarks:

This form was completed by: _______________________________ Date: __________
SECTION V: Follow Up Log (attach additional sheets as needed)

It is important to monitor all injuries. This can simply mean asking someone “how are you doing” within a reasonable time after the injury. Please note some reminder dates for follow-up inquiries on the log below as well as notes on any other conversation regarding the above incident (inform Personnel Officer of any updated information on the log).

Date:    Description:
Supervisor’s Injury/Illness Report

To be completed by the injured employee’s supervisor for any work-related injury or illness.

Date of Injury/Illness: ______________ Time: ____________

Supervisor: ___________________________ Department: ________________ Ext: _______

COMPLETE REPORT AND SUBMIT TO THE ASSOCIATED STUDENT’S HR MANAGER WITHIN 24 HOURS OF THE INJURY/ILLNESS OR AT THE BEGINNING OF THE FOLLOWING WORKDAY. PLEASE CALL (510) 885-3501 FOR ALL SERIOUS INJURIES OR FOR ASSISTANCE.

INJURED EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>EMPLOYEE STATUS:</th>
<th>Regular</th>
<th>Intermittent</th>
<th>Student</th>
<th>Non-Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
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<td></td>
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<tr>
<td>Home Phone #:</td>
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<tr>
<td>Address:</td>
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<td>City:</td>
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<td>Zip:</td>
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<tr>
<td>Date of Birth:</td>
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</tr>
<tr>
<td>Sex: M F</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Time Shift Started:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Job Title:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Avg. Weekly Hrs:</td>
<td>_____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Days: M T W Th F S S</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL TREATMENT INFORMATION

Was medical treatment necessary? □ Yes □ No
If yes, treatment at: □ St. Rose (OHC) □ CSUEB SHC
First aid administered by ___________________________ Type of first aid: ___________________________

Inured completed work shift? □ Yes □ No Comment: ___________________________

1. Where did the injury/illness occur? ___________________________
2. What was the employee doing at the time of the injury/illness? ___________________________
3. What was the cause of the injury/illness? ___________________________
4. Witnesses (names and phone #s): ___________________________
5. Describe the injury or illness: ___________________________
6. Part of body affected (be specific): ___________________________
7. What steps are necessary to prevent recurrence of a similar injury/illness? ___________________________
8. Have you taken these steps? □ Yes □ No Explain: ___________________________

____________________________________  __________________________
Supervisor’s Signature          Date               PI/Dept Head’s Signature                     Date
Worker’s Compensation
General Safety Information

All employees suffering from a job related injury or illness are entitled to worker’s compensation benefits. Benefits include:

- Payment of all medical costs including but not limited to: ambulance services, hospital stays, medication, transportation and other items deemed appropriate by our worker’s compensation carrier.

- Temporary disability payments if more than three working days are lost due to injury/illness. The first three days will be covered if more than 14 working days are lost. Temporary disability payments amount to approximately 2/3 of your weekly wages (up to a maximum of $490.00)

- Rehabilitation such as physical therapy that will help you return to work more quickly.

- Permanent disability payments may also be made if you are unable to return to work or after you return to work if the effects of the injury or illness are permanent (i.e. loss of a limb).

- In the case of an on the job death, benefits will be paid to the dependents of the employee.

The CSUEB Associated Student’s encourages all employees to take safety seriously. Be aware of hazards in the workplace, i.e. cords running across a walkway, spills, etc. and report them to your supervisor. Keep in mind safe lifting practices as well as applicable organizational safety policies and procedures.

Also be sure you report every injury no matter how minor. A cut finger can get infected and require serious medical treatment if not attended to properly. Any delay in reporting an injury can delay the receipt of worker’s compensation benefits.

In the case that you are injured on the job, please remember to share with the physician or hospital staff that you work for the CSUEB Associated Student’s. If you tell them that you work for California State University, East Bay we will not receive the paperwork in a timely manner and your benefits may be delayed.

The worker’s compensation insurance carrier is Sedgwick CMS.
I, the undersigned employee in case of an industrial injury or illness, elect to receive medical treatment from any personal physician/personal chiropractor.*

I understand that Labor Code Section 4600 defines my “personal physician” as my “regular physician and surgeon” who has previously directed my medical treatment and who retains my chiropractic records, including my medical history.

I understand that Labor Code Section 4601 defines my “personal chiropractor” as my “regular chiropractor” who has previously directed my treatment and who retains my chiropractic records, including my chiropractic history.

Check one:

☐ Personal Physician

Name

☐ Personal Chiropractor

Address

City    State    Zip

Telephone

Employee Name: ___________________________  Department: ____________________

Please Print

Signature: ____________________________________________ Date: _______________

Employer Use Only

Human Resources Officer: ___________________________ Date: __________

Date Superseded by Another Designation: ___________________________

* This form must be completed before the work-related injury occurs. If completed afterwards, injured employee must use the Saint Rose Occupational Health Center or the Student Health Center.