CWS
CAPITAL PARTNERS LLC
AN INVESTMENT MANAGEMENT COMPANY

Worker's Compensation
Guide to Work Related Injuries

Table of Contents

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What to do When an Employee Reports a Work Related Injury or Illness

Step 1: Remain calm and give First Aid (If Applicable) to employee (call 911 if necessary). If employee needs immediate medical attention, send them to nearest approved medical facility (see attached list of approved providers). Please note they must be seen at an approved facility unless the injury is an extreme medical emergency.

If the injury is a chemical related injury, send the SDS sheet for that chemical with the employee. If a death has occurred, contact OSHA IMMEDIATELY or within 8 hours. **If the employee does not need emergency treatment, please fill out the Provider Instruction Letter and Return to Work form prior to sending employee to clinic. These forms should be sent with the injured employee to the approved medical facility.**

Step 2: Determine if the injury is recordable. If the injured employee requires more than first aid (medical treatment at a facility) or requires time off from work, the injury **is** recordable.

If the injury is not recordable, you must still enter it into Riskonnect. **This completes your documentation of this injury, stop here.**

Step 3: If the employee requires medical attention other than first aid or has any time lost from work, the injury **is** recordable and must be reported to the CWS RISK AND INSURANCE DEPARTMENT immediately. To report this injury, simply enter incident into Riskonnect and select 'High' Priority.

Step 4: Record the injury on the OSHA 300 log.

Step 5: Every employee will be required to submit to drug and alcohol testing at the time of medical treatment. Fill out the instruction letter to the Medical Provider. This **must** be completed **prior** to sending the employee to the medical clinic (except in extreme medical emergencies). If necessary, contact the CWS Risk and Insurance Department.

Step 6: Send your employee to the nearest Approved Medical Provider with the letter of Provider Instruction and the Return to Work Status Form (both forms can be found in your Work Comp Kit).

Step 7: Evaluate the accident site immediately after the accident. Obtain names, addresses, and phone numbers of witnesses and take pictures if possible. Disengage any equipment suspected of contributing to the injury immediately and make any repair necessary to prevent another injury

Step 8: For California only – Your injured employee must fill out the top section of the DWC-1 form, the Community Director should fill in the bottom section of the form. Fax a copy to the Risk Management Director and provide a copy to the employee.

Step 10: EMPLOYEE RETURN TO WORK – After being seen by a physician the employee must return the completed Return to Work Status Form. It must be signed by his/her physician. The Return to Work Status is to be faxed or scanned to the Insurance and Risk department. Copies of the Return to Work Status are **not** to be kept onsite, they are to be returned to the employee or shredded.

The employee may return to work only if authorized to do so. If the employee is put on restricted duty, the CD will need contact the Risk and Insurance Department for instructions on any necessary payroll and work status changes.

In accordance with our Alcohol and Drug-Free Workplace policy, testing will be required. The employee will be allowed to return to work pending the test results unless otherwise determined by Human Resources. **If the CD or MD has suspicion that the injury may have been influenced by alcohol or drugs, they are to contact HR immediately.**

Step 11: FOLLOW UP MEDICAL VISITS – After each follow up visit, the employee must return the completed Return to Work Status Form to the CD. Please follow same instructions as above. This form must be received after EACH visit.

IMPORTANT NOTES:

If employee is not released to full or modified duty, please contact the Risk and Insurance Department immediately.

Employee should be paid for 8 hours of *regular pay* on the day of injury. Employee is to use sick or personal time for follow-up visits.

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Dear Medical Professional:

_____ has been involved in a possible work-related accident and is in need of medical attention. We are providing the following information to help with your care of our employee.

Employee Information:

Employee Name	
Address	
City, State, Zip	
Home Phone Number	
Job Title	
Hours worked per day	
Days worked per week	

Employer Information:

CWS Capital Partners LLC
Contact: Shanna Berrien
9606 N. Mopac Expressway, Ste. 500
Austin, TX 78759
sberrien@cwsapartments.com
512.682.6993
512.682.6994 Direct Fax

Carrier Information:

Hartford Insurance
1-800-327-3636
Policy #: 34WEZM7766

Drug/Alcohol Screening:

We are requesting a Standard 10-panel drug screen and breathe alcohol test and will require confirmation of the results. Test results should be sent or phoned to:

Sylvia Greene
9606 N. Mopac Expressway, Ste. #500
Austin, TX 78759
sgreene@cwsapartments.com
512-682-6931
512-682.6932 Direct Fax

Job Location:

Property Name	
Property Address	
City, State, Zip	
Property Phone Number	
Community Director	

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Job Responsibilities:

Description of Job Responsibilities	

Activity (hours per day)	Never 0 hours	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly 6- 8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck				
Twisting (waist)				
Hand Use: Dominant Hand (circle one) Right / Left				
Is repetitive use of hand required?				
Simple Grasping/right hand				
Simple Grasping/left hand				
Power Grasping/ right hand				
Power Grasping/ left hand				
Fine Manipulation/ Right hand				
Fine Manipulation/ Left Hand				

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Activity (hours per day)	Never 0 hours	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly 6- 8+ hours
Pushing & Pulling/ Right Hand				
Pushing & Pulling/ Left Hand				
Reaching/ above shoulder level				
Reaching /below shoulder level				

Indicate the dialing Lifting and Carrying requirements of the job.

Lifting:

Pounds	Never 0 Hours	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly 6 – 8+ hours	Height to be lifted
0-10					
11-25					
26-50					
51-75					
76-100					
101+					

Carrying:

Pounds	Never 0 Hours	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly 6 – 8+ hours	Height to be lifted
0-10					
11-25					
26-50					
51-75					
76-100					
101+					

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Describe the heaviest item required to carry and the distance to be carried:	

Does the Job Require the following:	Yes	No	If yes – Briefly Describe
Driving cars, trucks, golfcarts and other equipment?			
Working around equipment and machinery?			
Walking on uneven ground?			
Exposure to extremes in temperature, humidity or wetness?			
Exposure to dust, fumes or chemicals?			
Working at heights?			
Use of special visual or auditory equipment?			
Working with bio-hazards such as Blood borne pathogens, sewage, hospital waste, etc?			

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Our company believes our employees are the most important assets of our company.

We are committed to assisting our injured employees return to work as soon as medically appropriate and to work with the medical community to help the injured employees regain their livelihood. That is why we have implemented a return to work program designed to return any injured employee to medically appropriate work as soon as possible.

Please let us know if you need a more detailed job description. We will attempt to meet medical restrictions that may be assigned. If our employee is unable to return to his or her regular job, we will attempt to find an appropriate alternative work assignment. We will ensure that any assignment meets all medical requirements.

If you need any additional information about a possible work assignment or about our return to work program, please call Shanna Berrien at 512.682.6993 or sberrien@cwsapartments.com.

Thank you in our efforts to return our employees to a safe and productive workplace.

Employee Comments:	

Employer Comments:	

Employee's Signature:	Date:

Employer's Signature:	Date:

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Return-to-Work Status Form

Employee Instructions: Return this form to your supervisor/manager immediately after each visit to your health care provider.

To: _____ Re: _____
Examining Health Care Provider — Name of Insured Employee

From: CWS Capital Partners LLC _____
Name of Company — Social Security Number

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at our company. The information you provide on this for is vital to us regarding the following:

1. The employee's working without risk of further injury;
2. Provisions of a temporary duty assignment if necessary that meets the employee's needs and the needs of the company; and
3. Provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions, regarding the information requested on the form, please contact me.

Shanna Berrien, Director of Insurance and Risk 512.682.6993

To Be Completed by Physician

(see the next page for physical requirements of the employee's duties)

The injured employee's medical condition resulting from this worker's compensations injury will allow the employee

☐ Full Duty (without restrictions) _____
Beginning Date

☐ Temporary Assignment (modified or alternate duty): _____
Beginning Date

☐ Full-Time ☐ Part-Time _____hours per day

(Please indicate restrictions to duty on the next page)

☐ Off Work until re-evaluated, beginning date: _____

Date of next office visit: _____

_____ _____ _____
Physician's Name (printed) Physician's Signature Date

Please mark the column with a response of "Yes" if the employee can accomplish that specific task, or a response of "No" if the employee in unable to accomplish that specific task.

Requirements	Yes	No	Remarks		Requirements	Yes	No	Remarks
Lifting 51 lbs and up					Simple grasping			
Lifting 26-50 lbs					Power grasping			
Lifting up to 25 lbs					Simultaneous grasping			
Carrying 51 lbs. and up					Squeezing			
Carrying 26-50 lbs.					Driving motor vehicle			
Carrying up to 25 lbs.					Operating mechanical equipment			
Bending					Type:			
Stooping					Speaking			
Kneeling					Hearing			
Crawling					Ability to type			
Standing					Ability to see			
Squatting					Depth perception needed			
Climbing Stairs					Ability to write			
Climbing ladders					Ability to read			
Twisting					Vibration			
Pulling					Noise			
Pulling hand over hand					Extreme heat			
Pushing					Extreme cold			
Sitting					West and./or humid			
Walking					Chemicals			
Work on elevated surface								
Work on uneven ground								
Work at low position								
Reach above shoulders								
Reach below shoulders								
Able to intervene with individuals in combative or aggressive situations in an emergency								
Able to perform Cardiovascular Pulmonary Resuscitation (CPR) in an emergency.								

Please specify any additional restrictions to duty:_____

_____

_____

_____

_____

U.S. Department of Labor
Occupational Safety and Health Administration

OSHA Forms for Recording Work-Related Injuries and Illnesses

Dear Employer:

This booklet includes the forms needed for maintaining occupational injury and illness records for 2004. These new forms have changed in several important ways from the 2003 recordkeeping forms.

In the December 17, 2002 Federal Register (67 FR 77165-77170), OSHA announced its decision to add an occupational hearing loss column to OSHA's Form 300, Log of Work-Related Injuries and Illnesses. This forms package contains modified Forms 300 and 300A which incorporate the additional column M(5) Hearing Loss. Employers required to complete the injury and illness forms must begin to use these forms on January 1, 2004.

In response to public suggestions, OSHA also has made several changes to the forms package to make the recordkeeping materials clearer and easier to use:

- On Form 300, we've switched the positions of the day count columns. The days "away from work" column now comes before the days "on job transfer or restriction."
- We've clarified the formulas for calculating incidence rates.
- We've added new recording criteria for occupational hearing loss to the "Overview" section.
- On Form 300, we've made the column heading "Classify the Case" more prominent to make it clear that employers should mark only one selection among the four columns offered.

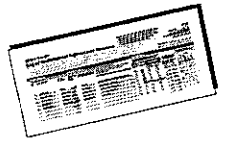
The Occupational Safety and Health Administration shares with you the goal of preventing injuries and illnesses in our nation's workplaces. Accurate injury and illness records will help us achieve that goal.

Occupational Safety and Health Administration
U.S. Department of Labor

What's Inside...

In this package, you'll find everything you need to complete OSHA's *Log* and the *Summary of Work-Related Injuries and Illnesses* for the next several years. On the following pages, you'll find:

- ***An Overview: Recording Work-Related Injuries and Illnesses*** — General instructions for filling out the forms in this package and definitions of terms you should use when you classify your cases as injuries or illnesses.
- ***How to Fill Out the Log*** — An example to guide you in filling out the *Log* properly.
- ***Log of Work-Related Injuries and Illnesses*** — Several pages of the *Log* (but you may make as many copies of the *Log* as you need.) Notice that the *Log* is separate from the *Summary*.



- ***Summary of Work-Related Injuries and Illnesses*** — Removable *Summary* pages for easy posting at the end of the year. Note that you post the *Summary* only, not the *Log*.

- ***Worksheet to Help You Fill Out the Summary*** — A worksheet for figuring the average number of employees who worked for your establishment and the total number of hours worked.
- ***OSHA's 301: Injury and Illness Incident Report*** — A copy of the OSHA 301 to provide details about the incident. You may make as many copies as you need or use an equivalent form.

Take a few minutes to review this package. If you have any questions, ***visit us online at www.osha.gov or call your local OSHA office.*** We'll be happy to help you.

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An Overview: Recording Work-Related Injuries and Illnesses

The Occupational Safety and Health (OSH) Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Use these definitions when you classify cases on the Log. OSHA's recordkeeping regulation (see 29 CFR Part 1904) provides more information about the definitions below.

The *Log of Work-Related Injuries and Illnesses* (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened. The *Summary* — a separate form (Form 300A) — shows the totals for the year in each category. At the end of the year, post the *Summary* in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace.

Employers must keep a *Log* for each establishment or site. If you have more than one establishment, you must keep a separate *Log* and *Summary* for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury and illness records. For more information, see 29 Code of Federal Regulations Part 1904.35, *Employee Involvement.*

Cases listed on the *Log of Work-Related Injuries and Illnesses* are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case on the *Log* does not mean that the employer or worker was at fault or that an OSHA standard was violated.

When is an injury or illness considered work-related?

An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. See 29 CFR Part 1904.5(b)(2) for the exceptions. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment. See 29 CFR Part 1904.5(b)(1).

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in:

- death,
- loss of consciousness,
- days away from work,
- restricted work activity or job transfer, or
- medical treatment beyond first aid.

You must also record work-related injuries and illnesses that are significant (as defined below) or meet any of the additional criteria listed below.

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum. See 29 CFR 1904.7.

What are the additional criteria?

You must record the following conditions when they are work-related:

- any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material;
- any case requiring an employee to be medically removed under the requirements of an OSHA health standard;
- tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional after exposure to a known case of active tuberculosis.
- an employee's hearing test (audiogram) reveals 1) that the employee has experienced a Standard Threshold Shift (STS) in hearing in one or both ears (averaged at 2000, 3000, and 4000 Hz) and 2) the employee's total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 Hz) in the same ear(s) as the STS.

What is medical treatment?

Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are NOT recordable:

- visits to a doctor or health care professional solely for observation or counseling;

What do you need to do?

1. Within 7 calendar days after you receive information about a case, decide if the case is recordable under the OSHA recordkeeping requirements.
2. Determine whether the incident is a new case or a recurrence of an existing one.
3. Establish whether the case was work-related.
4. If the case is recordable, decide which form you will fill out as the injury and illness incident report.

   You may use *OSHA's 301: Injury and Illness Incident Report* or an equivalent form. Some state workers compensation, insurance, or other reports may be acceptable substitutes, as long as they provide the same information as the OSHA 301.

How to work with the Log

1. Identify the employee involved unless it is a privacy concern case as described below.
2. Identify when and where the case occurred.
3. Describe the case, as specifically as you can.
4. Classify the seriousness of the case by recording the **most serious outcome** associated with the case, with column G (Death) being the most serious and column J (Other recordable cases) being the least serious.
5. Identify whether the case is an injury or illness. If the case is an injury, check the injury category. If the case is an illness, check the appropriate illness category.

U.S. Department of Labor
Occupational Safety and Health Administration

- diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes; and
- any procedure that can be labeled first aid. (*See below for more information about first aid.*)

What is first aid?

If the incident required only the following types of treatment, consider it first aid. Do NOT record the case if it involves only:

- using non-prescription medications at non-prescription strength;
- administering tetanus immunizations;
- cleaning, flushing, or soaking wounds on the skin surface;
- using wound coverings, such as bandages, BandAids™, gauze pads, etc., or using SteriStrips™ or butterfly bandages.
- using hot or cold therapy;
- using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
- using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards).
- drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters;
- using eye patches;
- using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
- using irrigation, tweezers, cotton swab or other simple means to remove splinters or foreign material from areas other than the eye;
- using finger guards;
- using massages;
- drinking fluids to relieve heat stress

How do you decide if the case involved restricted work?

Restricted work activity occurs when, as the result of a work-related injury or illness, an employer or health care professional keeps, or recommends keeping, an employee from doing the routine functions of his or her job or from working the full workday that the employee would have been scheduled to work before the injury or illness occurred.

How do you count the number of days of restricted work activity or the number of days away from work?

Count the number of calendar days the employee was on restricted work activity or was away from work as a result of the recordable injury or illness. Do not count the day on which the injury or illness occurred in this number. Begin counting days from the day after the incident occurs. If a single injury or illness involved both days away from work and days of restricted work activity, enter the total number of days for each. You may stop counting days of restricted work activity or days away from work once the total of either or the combination of both reaches 180 days.

Under what circumstances should you NOT enter the employee's name on the OSHA Form 300?

You must consider the following types of injuries or illnesses to be privacy concern cases:

- an injury or illness to an intimate body part or to the reproductive system,
- an injury or illness resulting from a sexual assault,
- a mental illness,
- a case of HIV infection, hepatitis, or tuberculosis,
- a needlestick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material (see 29 CFR Part 1904.8 for definition), and
- other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log.

You must not enter the employee's name on the OSHA 300 *Log* for these cases. Instead, enter "privacy case" in the space normally used for the employee's name. You must keep a separate, confidential list of the case numbers and employee names for the establishment's privacy concern cases so that you can update the cases and provide information to the government if asked to do so.

If you have a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee's name has been omitted, you may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. You must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but you do not need to include details of an intimate or private nature.

What if the outcome changes after you record the case?

If the outcome or extent of an injury or illness changes after you have recorded the case, simply draw a line through the original entry or, if you wish, delete or white-out the original entry. Then write the new entry where it belongs. Remember, you need to record the most serious outcome for each case.

Classifying injuries

An injury is any wound or damage to the body resulting from an event in the work environment.

Examples: Cut, puncture, laceration, abrasion, fracture, bruise, contusion, chipped tooth, amputation, insect bite, electrocution, or a thermal, chemical, electrical, or radiation burn. Sprain and strain injuries to muscles, joints, and connective tissues are classified as injuries when they result from a slip, trip, fall or other similar accidents.

U.S. Department of Labor
Occupational Safety and Health Administration

Classifying illnesses

Skin diseases or disorders
Skin diseases or disorders are illnesses involving the worker's skin that are caused by work exposure to chemicals, plants, or other substances.

Examples: Contact dermatitis, eczema, or rash caused by primary irritants and sensitizers or poisonous plants; oil acne; friction blisters, chrome ulcers; inflammation of the skin.

Respiratory conditions
Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dust, gases, vapors, or fumes at work.

Examples: Silicosis, asbestosis, pneumonitis, pharyngitis, rhinitis or acute congestion; farmer's lung, beryllium disease, tuberculosis, occupational asthma, reactive airways dysfunction syndrome (RADS), chronic obstructive pulmonary disease (COPD), hypersensitivity pneumonitis, toxic inhalation injury, such as metal fume fever, chronic obstructive bronchitis, and other pneumoconioses.

Poisoning
Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues, other bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body.

Examples: Poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzene, benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays, such as parathion or lead arsenate; poisoning by other chemicals, such as formaldehyde.

Hearing Loss
Noise-induced hearing loss is defined for recordkeeping purposes as a change in hearing threshold relative to the baseline audiogram of an average of 10 dB or more in either ear at 2000, 3000 and 4000 hertz, and the employee's total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 hertz) in the same ear(s).

All other illnesses
All other occupational illnesses.

Examples: Heatstroke, sunstroke, heat exhaustion, heat stress and other effects of environmental heat; freezing, frostbite, and other effects of exposure to low temperatures; decompression sickness; effects of ionizing radiation (isotopes, x-rays, radium); effects of nonionizing radiation (welding flash, ultra-violet rays, lasers); anthrax; bloodborne pathogenic diseases, such as AIDS, HIV, hepatitis B or hepatitis C; brucellosis; malignant or benign tumors; histoplasmosis; coccidioidomycosis.

When must you post the Summary?

You must post the *Summary* only — not the *Log* — by February 1 of the year following the year covered by the form and keep it posted until April 30 of that year.

How long must you keep the Log and Summary on file?

You must keep the *Log* and *Summary* for 5 years following the year to which they pertain.

Do you have to send these forms to OSHA at the end of the year?

No. You do not have to send the completed forms to OSHA unless specifically asked to do so.

How can we help you?

If you have a question about how to fill out the *Log*,

- ❑ **visit us online at www.osha.gov** or
- ❑ **call your local OSHA office.**

Optional

Calculating Injury and Illness Incidence Rates

What is an incidence rate?

An incidence rate is the number of recordable injuries and illnesses occurring among a given number of full-time workers (usually 100 full-time workers) over a given period of time (usually one year). To evaluate your firm's injury and illness experience over time or to compare your firm's experience with that of your industry as a whole, you need to compute your incidence rate. Because a specific number of workers and a specific period of time are involved, these rates can help you identify problems in your workplace and/or progress you may have made in preventing work-related injuries and illnesses.

How do you calculate an incidence rate?

You can compute an occupational injury and illness incidence rate for all recordable cases or for cases that involved days away from work for your firm quickly and easily. The formula requires that you follow instructions in paragraph (a) below for the total recordable cases or those in paragraph (b) for cases that involved days away from work, *and* for both rates the instructions in paragraph (c).

(a) *To find out the total number of recordable injuries and illnesses that occurred during the year,* count the number of line entries on your OSHA Form 300, or refer to the OSHA Form 300A and sum the entries for columns (G), (H), (I), and (J).

(b) *To find out the number of injuries and illnesses that involved days away from work,* count the number of line entries on your OSHA Form 300 that received a check mark in column (H), or refer to the entry for column (H) on the OSHA Form 300A.

(c) *The number of hours all employees actually worked during the year.* Refer to OSHA Form 300A and optional worksheet to calculate this number.

You can compute the incidence rate for all recordable cases of injuries and illnesses using the following formula:

Total number of injuries and illnesses x *200,000* ÷ *Number of hours worked by all employees* = *Total recordable case rate*

(The 200,000 figure in the formula represents the number of hours 100 employees working 40 hours per week, 50 weeks per year would work, and provides the standard base for calculating incidence rates.)

You can compute the incidence rate for recordable cases involving days away from work, days of restricted work activity or job transfer (DART) using the following formula:

(Number of entries in column H + Number of entries in column I) x *200,000* ÷ *Number of hours worked by all employees* = *DART incidence rate*

You can use the same formula to calculate incidence rates for other variables such as cases involving restricted work activity (column (I) on Form 300A), cases involving skin disorders (column (M-2) on Form 300A), etc. Just substitute the appropriate total for these cases, from Form 300A, into the formula in place of the total number of injuries and illnesses.

What can I compare my incidence rate to?

The Bureau of Labor Statistics (BLS) conducts a survey of occupational injuries and illnesses each year and publishes incidence rate data by various classifications (e.g., by industry, by employer size, etc.). You can obtain these published data at www.bls.gov/iif or by calling a BLS Regional Office.

Worksheet

Total number of injuries and illnesses			Number of hours worked by all employees		Total recordable case rate
	X 200,000	÷		=	

Number of entries in Column H + Column I			Number of hours worked by all employees		DART incidence rate
	X 200,000	÷		=	

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Occupational Safety and Health Administration

How to Fill Out the Log

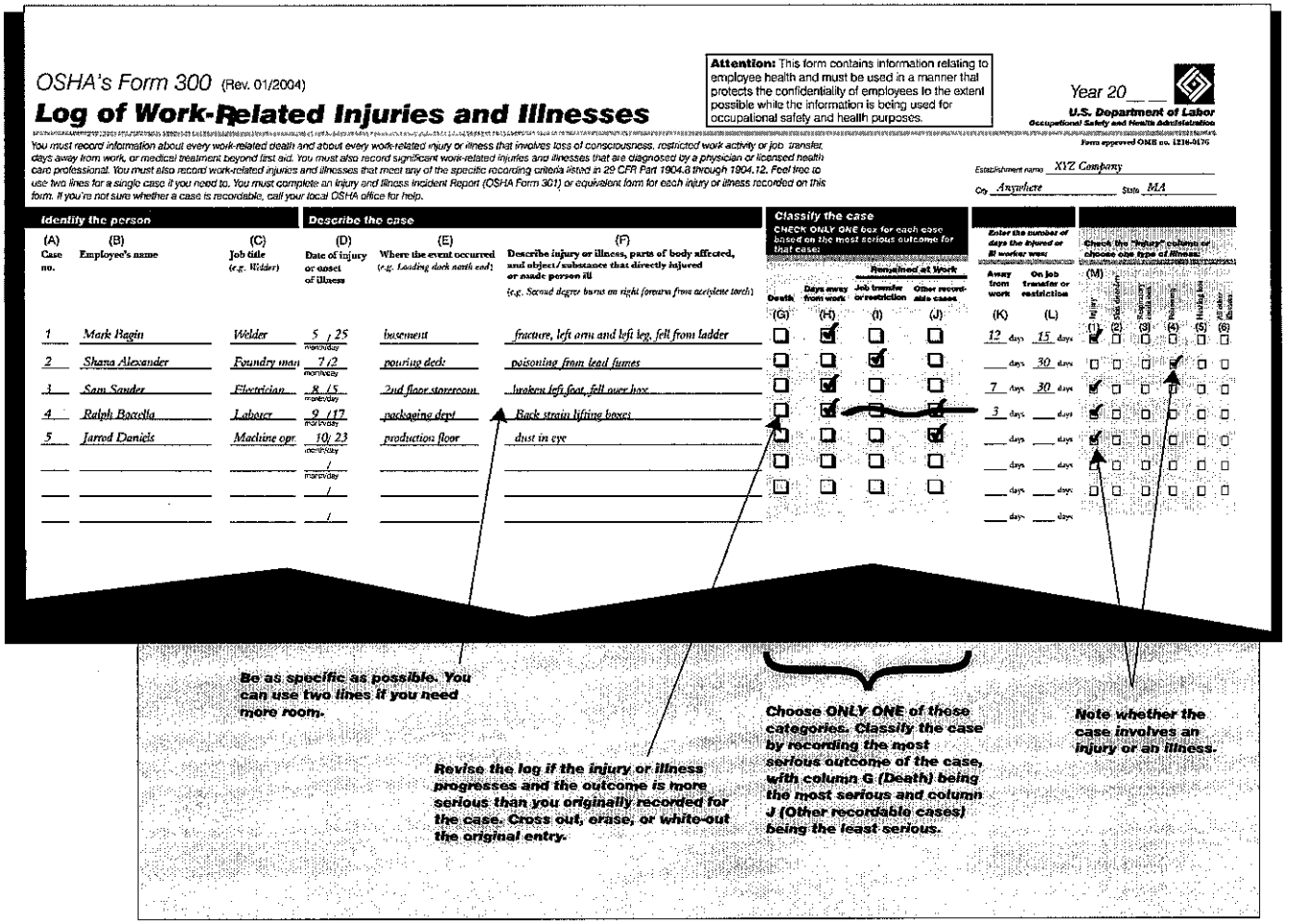
The *Log of Work-Related Injuries and Illnesses* is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened.

If your company has more than one establishment or site, you must keep separate records for each physical location that is expected to remain in operation for one year or longer.

We have given you several copies of the *Log* in this package. If you need more than we provided, you may photocopy and use as many as you need.

The *Summary* — a separate form — shows the work-related injury and illness totals for the year in each category. At the end of the year, count the number of incidents in each category and transfer the totals from the *Log* to the *Summary*. Then post the *Summary* in a visible location so that your employees are aware of injuries and illnesses occurring in their workplace.

You don't post the Log. You post only the Summary at the end of the year.



OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

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.

Year 20 __

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name XYZ Company
City Anywhere State MA

Identify the person			Describe the case			Classify the case (CHECK ONLY ONE box for each case based on the most serious outcome for that case)				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
							Remained at Work										
(A) Case no.	(B) Employee's name	(C) Job title (e.g. Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g. Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from accidental torch)	Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
1	Mark Bagin	Welder	5/25	basement	fracture, left arm and left leg, fell from ladder	☐	☑	☐	☐	12 days	15 days	☑	☐	☐	☐	☐	☐
2	Shana Alexander	Foundry man	7/2	pouring deck	poisoning from lead fumes	☐	☐	☑	☐	___ days	30 days	☐	☐	☐	☑	☐	☐
3	Sam Sauder	Electrician	8/5	2nd floor storeroom	broken left foot, fell over box	☐	☑	☐	☐	7 days	30 days	☑	☐	☐	☐	☐	☐
4	Ralph Bocella	Laborer	9/17	packaging dept	Back strain lifting boxes	☐	☑	☐	☐	3 days	___ days	☑	☐	☐	☐	☐	☐
5	Jarrod Daniels	Machine opr	10/23	production floor	dust in eye	☐	☐	☐	☑	___ days	___ days	☑	☐	☐	☐	☐	☐
			/			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐

Be as specific as possible. You can use two lines if you need more room.

Revise the log if the injury or illness progresses and the outcome is more serious than you originally recorded for the case. Cross out, erase, or white-out the original entry.

Choose ONLY ONE of these categories. Classify the case by recording the most serious outcome of the case, with column G (Death) being the most serious and column J (Other recordable cases) being the least serious.

Note whether the case involves an injury or an illness.

U.S. Department of Labor
Occupational Safety and Health Administration

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

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.

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name ______________________

City ______________________ State ____________

Identify the person			Describe the case			Classify the case: CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness: (M)					
								Remained at Work									
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., Welder*)	(D) Date of injury or onset of illness	(E) Where the event occurred (*e.g., Loading dock north end*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., Second degree burns on right forearm from acetylene torch*)	Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other record-able cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			/ month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
					Page totals	___	___	___	___	___	___	___	___	___	___	___	___
												Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year 20__ __

U.S. Department of Labor
Occupational Safety and Health Administration
Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of . . .

	(M)		(M)
(1) Injuries	_____	(4) Poisonings	_____
		(5) Hearing loss	_____
(2) Skin disorders	_____	(6) All other illnesses	_____
(3) Respiratory conditions	_____		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ ZIP _____

Industry description (*e.g., Manufacture of motor truck trailers*)

_____

Standard Industrial Classification (SIC), if known (*e.g., 3715*)

__ __ __ __

OR

North American Industrial Classification (NAICS), if known (e.g., 336212)

__ __ __ __ __ __

Employment information *(If you don't have these figures, see the Worksheet on the back of this page to estimate.)*

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____ _____
Company executive Title

( ) - / /
Phone Date

U.S. Department of Labor
Occupational Safety and Health Administration

Optional

Worksheet to Help You Fill Out the Summary

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the summary. If you don't have these figures, you can use the information on this page to estimate the numbers you will need to enter on the Summary page at the end of the year.

How to figure the average number of employees who worked for your establishment during the year:

❶ ***Add*** the total number of employees your establishment paid in all pay periods during the year. Include all employees: full-time, part-time, temporary, seasonal, salaried, and hourly.

The number of employees paid in all pay periods = ❶ _____

❷ ***Count*** the number of pay periods your establishment had during the year. Be sure to include any pay periods when you had no employees.

The number of pay periods during the year = ❷ _____

❸ ***Divide*** the number of employees by the number of pay periods.

❶ _____ / ❷ _____ = ❸ _____

❹ ***Round the answer*** to the next highest whole number. Write the rounded number in the blank marked *Annual average number of employees.*

The number rounded = ❹ _____

For example, Acme Construction figured its average employment this way:

For pay period...	Acme paid this number of employees...
1	10
2	0
3	15
4	30
5	40
▼	▼
24	20
25	15
26	+10
	830

Number of employees paid = 830 ❶

Number of pay periods = 26 ❷

830 / 26 = 31.92 ❸

31.92 rounds to 32 ❹

32 is the annual average number of employees

How to figure the total hours worked by all employees:

Include hours worked by salaried, hourly, part-time and seasonal workers, as well as hours worked by other workers subject to day to day supervision by your establishment (e.g., temporary help services workers).

Do not include vacation, sick leave, holidays, or any other non-work time, even if employees were paid for it. If your establishment keeps records of only the hours paid or if you have employees who are not paid by the hour, please estimate the hours that the employees actually worked.

If this number isn't available, you can use this optional worksheet to estimate it.

Optional Worksheet

_____ ***Find*** the number of full-time employees in your establishment for the year.

X _____ ***Multiply*** by the number of work hours for a full-time employee in a year.

_____ This is the number of full-time hours worked.

\+ _____ ***Add*** the number of any overtime hours as well as the hours worked by other employees (part-time, temporary, seasonal)

_____ ***Round*** the answer to the next highest whole number. Write the rounded number in the blank marked *Total hours worked by all employees last year.*

OSHA's Form 301
Injury and Illness Incident Report

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.

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____)_____–_____ **Date** ____/____/____

Information about the employee

1) **Full name** _____

2) **Street** _____

City _____ **State** _____ **ZIP** _____

3) **Date of birth** ____/____/____

4) **Date hired** ____/____/____

5) ☐ **Male**
☐ **Female**

Information about the physician or other health care professional

6) **Name of physician or other health care professional** _____

_____

7) **If treatment was given away from the worksite, where was it given?**

Facility _____

Street _____

City _____ **State** _____ **ZIP** _____

8) **Was employee treated in an emergency room?**
☐ **Yes**
☐ **No**

9) **Was employee hospitalized overnight as an in-patient?**
☐ **Yes**
☐ **No**

Information about the case

10) **Case number from the *Log*** _____ *(Transfer the case number from the Log after you record the case.)*

11) **Date of injury or illness** ____/____/____

12) **Time employee began work** _____ **AM / PM**

13) **Time of event** _____ **AM / PM** ☐ **Check if time cannot be determined**

14) ***What was the employee doing just before the incident occurred?*** **Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.** *Examples:* **"climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."**

15) ***What happened?*** **Tell us how the injury occurred.** *Examples:* **"When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."**

16) ***What was the injury or illness?*** **Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore."** *Examples:* **"strained back"; "chemical burn, hand"; "carpal tunnel syndrome."**

17) ***What object or substance directly harmed the employee?*** *Examples:* **"concrete floor"; "chlorine"; "radial arm saw."** ***If this question does not apply to the incident, leave it blank.***

18) ***If the employee died, when did death occur?*** **Date of death** ____/____/____

If You Need Help...

If you need help deciding whether a case is recordable, or if you have questions about the information in this package, feel free to contact us. We'll gladly answer any questions you have.

- **Visit us online at www.osha.gov**
- **Call your OSHA Regional office and ask for the recordkeeping coordinator**

  or

- **Call your State Plan office**

Federal Jurisdiction

Region 1 - 617 / 565-9860
Connecticut; Massachusetts; Maine; New Hampshire; Rhode Island

Region 2 - 212 / 337-2378
New York; New Jersey

Region 3 - 215 / 861-4900
DC; Delaware; Pennsylvania; West Virginia

Region 4 - 404 / 562-2300
Alabama; Florida; Georgia; Mississippi

Region 5 - 312 / 353-2220
Illinois; Ohio; Wisconsin

Region 6 - 214 / 767-4731
Arkansas; Louisiana; Oklahoma; Texas

Region 7 - 816 / 426-5861
Kansas; Missouri; Nebraska

Region 8 - 303 / 844-1600
Colorado; Montana; North Dakota; South Dakota

Region 9 - 415 / 975-4310

Region 10 - 206 / 553-5930
Idaho

State Plan States

Alaska - 907 / 269-4957

Arizona - 602 / 542-5795

California - 415 / 703-5100

*Connecticut - 860 / 566-4380

Hawaii - 808 / 586-9100

Indiana - 317 / 232-2688

Iowa - 515 / 281-3661

Kentucky - 502 / 564-3070

Maryland - 410 / 767-2371

Michigan - 517 / 322-1848

Minnesota - 651 / 284-5050

Nevada - 702 / 486-9020

*New Jersey - 609 / 984-1389

New Mexico - 505 / 827-4230

*New York - 518 / 457-2574

North Carolina - 919 / 807-2875

Oregon - 503 / 378-3272

Puerto Rico - 787 / 754-2172

South Carolina - 803 / 734-9669

Tennessee - 615 / 741-2793

Utah - 801 / 530-6901

Vermont - 802 / 828-2765

Virginia - 804 / 786-6613

Virgin Islands - 340 / 772-1315

Washington - 360 / 902-5601

Wyoming - 307 / 777-7786

*Public Sector only

U.S. Department of Labor
Occupational Safety and Health Administration

U.S. Department of Labor
Occupational Safety and Health Administration

Have questions?

If you need help in filling out the *Log* or *Summary*, or if you have questions about whether a case is recordable, contact us. We'll be happy to help you. You can:

- Visit us online at: **www.osha.gov**
- Call your regional or state plan office. You'll find the phone number listed inside this cover.

WORKERS' COMPENSATION CLAIM
TELEPHONE REPORTING

TO REPORT A WORKERS' COMPENSATION CLAIM

When an employee is injured, the most important thing is to secure appropriate medical treatment. Once this has been done, the claim should be called into the Telephone Reporting Center.

Suggested Steps:

1. **Gather the facts.**

   Use the WORKERS' COMPENSATION TELEPHONE REPORTING GUIDE as a reference.

   The objective is to report the claim quickly. Prompt reporting is essential for quickly determining the appropriate medical treatment. It also helps expedite claim resolution and helps return your employees to work quicker. We must have the employee's name, social security number and a description of the accident. Try to gather as much information as possible, but don't worry if you do not have the answers to every question.

   Worksheets are provided for you convenience. It is not necessary to write answers to questions you know. The worksheet is a tool to help reduce the amount of time you are on the telephone.

2. **Call the Customer Service Unit**

   When you call the 800 number provided, you will be greeted on the telephone by a customer service representative who will complete the state specific notice of injury by asking you the necessary questions. The order of the questions will be the same every time you call.

   The questions are grouped in three sections:

   - General Questions
     This section contains questions specific to you, your employee and the accident. These questions will be asked on every claim.

   - State Specific Questions
     If the jurisdiction requires data not covered in the general section, it will be covered here.

   - Additional Comments and Information
     If you would like to provide additional information not covered elsewhere, the customer service representative will record this in a free form area.

3. **Let Your Employee Know**

   Before you hang up, the customer service representative will give you a claim number. Using the claim number will help expedite handling the rest of the claim. Please include the claim number with all future correspondence, such as wage statements or medical bills. Please be sure to give this number to your employee.

WORKERS' COMPENSATION TELEPHONE REPORTING GUIDE

Please do not delay in reporting the claim even if you do not have all the necessary information. We will produce and submit the necessary forms.

Account/Accident Information

Caller's phone number and extension
Caller's title and name
Reporting state – state where EE is permanently employed
Subsidiary name and address
Subsidiary mailing address (if different from above)
Did the accident occur at the location address? (if no, address where accident occurred)
Parent company / Insured's name
Location code
Policy symbol and number
Nature of business

Employee Information

Employee's name
Gender
Social security number
Date of birth
Employee's mailing address
Employee's home phone number
Employee's home address (if different from mailing)

Employee Job Information

Employment status code (FT, PT, seasonal, volunteer, etc.)
Injured worker type (borrowed, owner, partner, subcontractor, unknown)
Regular occupation
Occupation when injured
Employee's work schedule (regular work hours, hours per day, days per week)
Employee's wage information (hourly, annual, average weekly, overtime, and additional benefits)
Date of hire (or length of employment)
Supervisor's name, phone number and best hours to contact

Accident Information

Date of injury
Time of injury
Date claim reported to employer
Did employee lose any time from work? If yes,
  Is employee back at work? (if yes, date returned)
Return to work status (light, modified, regular)
Date employee last worked
Was injury fatal? (if yes, date of death)
Accident description
Do you question the validity of this claim?
Cause of accident (e.g., slip/fall, lifting, chemical)
Equipment, material, or substance involved
Names, addresses and phone numbers of witnesses

Injury Information

Part of body injured (e.g., head, neck, arm, leg)
Nature of injury (e.g., fracture, sprain, laceration)
Prior injury or pre-existing condition(s) (if yes, describe)
Treatment - Note all that apply.
  First-aid (treatment and date of 1st treatment)
  Hospital/Clinic (name, address, phone number, physician name, treatment, date of 1st treatment, length of stay, ambulance used?)
  Was employee treated in an emergency room?
  Was employee hospitalized overnight as an inpatient?
  Physician (name, address, phone number, treatment, date of 1st treatment, specialty)

State Specific Information

See WORKERS COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS for your individual state.

Comments

WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:
Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			

SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER_____	INJURED WORKER TYPE	REGULAR OCCUPATION

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:
$_____/ HOUR OR $_____/ ANNUAL OR $_____/ WEEKLY OVERTIME: $_____ ADDITIONAL BENEFITS: $_____

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: ( )	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? ☐ YES ☐ NO	IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS ☐ LIGHT ☐ MODIFIED ☐ REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?
☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT"? ☐ YES ☐ NO
☐ PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación para 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. For injuries occurring on or after 1/1/04, 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. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. 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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same 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, you will receive temporary disability payments. 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.

Si Ud. se lesiona o se enferma, ya sea física 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 para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para 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/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete 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/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) 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(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para 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 pre-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 especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

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

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

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 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.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return 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. SJDB is a benefit for injuries occurring on or after 1/1/04.

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, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

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**.

impuestos. Los pagos 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(a) de 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/la administrador(a) 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 extenderse o no temporalmente, 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.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne 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(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

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 vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de 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 al Trabajador *(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 ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

SAVE PRINT CLEAR

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 trabjador.*

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*

7/1/04 Rev.

CWS
CAPITAL
PARTNERS
LLC
AN INVESTMENT MANAGEMENT COMPANY

Dear Medical Professional:

As part of our Bloodborne Pathogen program our employee, _____ is requesting the Hepatitis B vaccination series.

You have our authorization to direct bill us for this vaccination. We are providing the following information to help with your care of our employee.

Employee Information:

Employee Name	
Date of Birth	
Social Security Number	
Address	
City, State, Zip	
Hours worked per day	
Days worked per week	

Employer and Billing Information:

CWS Capital Partners LLC
Contact: Sylvia Greene
9606 N. Mopac Expressway, Ste. 500
Austin, TX 78759
512.682.6931 Direct
512.682.6932 Direct Fax

Job Location:

Property Name	
Property Address	
City, State, Zip	
Property Phone Number	
Community Director	

Please feel free to contact us directly if you need any further information.

Authorized by:_____ Title:_____

Phone: _____ Date: _____