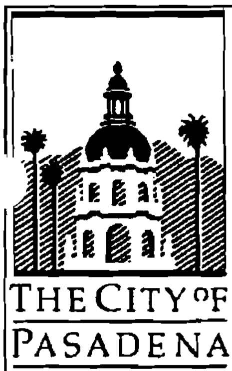

MANUAL OF PERSONNEL RULES, PRACTICES, AND PROCEDURES

SUPERSEDES: August 15, 1992

NEW EFFECTIVE DATE: June 1, 1993

APPROVED BY CITY MANAGER:

I. Objective

A. To establish administrative guidelines for providing fair and impartial medical treatment and Worker's Compensation benefits for persons incapacitated by job-related injury or illness in the course and scope of their employment with the City of Pasadena.

B. To provide policies and procedures for application of Worker's Compensation benefits as prescribed by Worker's Compensation laws of the State of California and the memorandum of understanding and/or City resolution covering the classification.

C. To establish administrative guidelines and procedures for job-related illness and injury reporting and investigation.

II. Definitions

A. Job-Related Illness or Injury - An injury or illness arising out of or occurring in the course and scope of employment or work with the City of Pasadena.

B. Supplementary Disability Benefits - Benefits provided in lieu of or in addition to those prescribed by Worker's Compensation laws of the State of California or prescribed under the Memorandum of Understanding and/or City Salary Resolution covering the classification.

C. Illness or Injury as used in this policy shall mean job-related illness or injury.

D. Application as used in this Policy shall mean the "Application for Payment of Wages During Absence" form.

III. Policy

A. Worker's Compensation

1. Employees of the City of Pasadena are covered under the Worker's Compensation laws of the State of California.

2. The City will fund and administer its own Worker's Compensation program as authorized by the State of California. Legal and administrative consultants may be hired to assist and advise in the conduct of the program.

3. Benefits prescribed by law include but are not limited to the following:

   a. Medical treatment;

   b. Temporary disability payments;

   c. Permanent disability payments; and

   d. Vocational rehabilitation.

4. Sick leave benefits may not be applied to job-related injury or illness except as otherwise authorized by Salary Resolution or Memorandum of Understanding.

B. Medical Services

1. During normal working hours, the first treatment for injuries or referral to physicians will be coordinated through the Worker's Compensation Section of the Human Resources Department.

2. The City will provide all medical care necessary to treat an employee for the effects of an industrial injury as provided under the Labor Code of the State of California.

3. First treatment or referral for illness or injury shall be as directed by Section 6.25 Item III-C of this policy.

4. An employee shall not be returned to his/her present position, nor be placed in a new position until medically approved for duty through the Human Resources Department.

5. Where crisis intervention or psychological counseling is required or appropriate, the department will contact the Worker's Compensation Section immediately for referral purposes.

C. Transporting Injured Employees

1. If medical treatment is necessary, a foreman or supervisor will see that the injured employee is provided prompt transportation for treatment to the Center for Occupational Health at the Huntington Memorial Hospital, or to an appropriate medical facility.

2. If there is any question of the seriousness of the injury or if the employee specifically requests medical treatment, transportation will be provided to the Center for Occupational Health or an appropriate medical facility.

D. Reporting of Injuries

1. Personal injuries on the job, however slight, must be reported to a foreman or supervisor immediately.

2. After the immediate medical needs of the injured employee have been met, but not later than 12 hours after the injury, the employee shall be given "Employee/Employer Report of Occupational Injury or Illness" (see exhibit at end of this section). The employee shall be required to sign the "Employee's Claim for Worker's Compensation Benefits" form (see exhibit at end of this section) indicating he/she has received the report of injury form. The supervisor will sign and date the form in the presence of the employee verifying the employee received the form within 24 hours of the date of knowledge of the alleged accident.

   The foreman or supervisor will assist the employee, as necessary, to complete the form in order to provide a thorough, comprehensive and legible report. The "Supervisor's" portion of the report will be completed by a foreman or supervisor.

3. As soon as possible, but within 24 hours, the supervisor shall process a "Supervisor's Accident Investigation Report" (see exhibit at end of this section).

4. The supervisor investigating the "Job-Related Injury or Illness" is expected to make a complete analysis of the situation and when recommending action for prevention to follow such recommendations to completion. The status of recommendations to prevent a reoccurrence shall be submitted to the Human Resources Department the day following the supervisor's report.

5. When an employee is off the job because of a work related injury or illness, the department shall coordinate with the Worker's Compensation Section of Human Resources and the Finance Department to ensure that the employee receives all benefits to which he/she may be entitled.

E. Recovery and Rehabilitation Services

1. The City shall endeavor to return a disabled employee to regular duty as soon as possible after a job-related illness or injury.

2. The City shall endeavor to provide reasonable accommodation to retain and/or place full-time employees who have become disabled by illness or injury into jobs for which they may qualify by previous training or experience.

3. If it is determined by the Human Resources Director, based on medical information, that an injured employee is capable of performing duties other than his/her regular work during the period of recuperation, the employee may be given a modified work assignment.

4. The department shall make every effort to place injured employees in modified work assignments within their own department. If unable to do so, employees may be assigned by the Director of Human Resources to modified work assignments within any department of the City. Payroll will be charged to the home department.

5. Modified work assignments will be for a specific period of time as determined by the Director of Human Resources in cooperation with the participating department. Modified work assignments will be evaluated every 30 calendar days and shall not exceed 90 calendar days without the approval of the Director of Human Resources.

6. Employees performing in modified work assignments will be paid at their regular compensation rate until it is determined by the Director of Human Resources that they cannot return to their regular classification because of medical limitations.

7. Upon the determination by the Director of Human Resources, that an employee may not or cannot be reasonably accommodated in accordance with State and Federal law, and cannot be returned to his/her regular assignment because of medical limitations, he/she may be certified to a job vacancy for which he/she is qualified, or be separated from employment.

8. Injured or disabled employees who are unable to return to their regular duties must qualify for other job classifications through the regular merit system standards as established by the Human Resources Department; and if appointed to another job, will be subject to a new probationary period.

9. The Worker's Compensation Section of the Human Resources Department will notify employees of their rights to vocational rehabilitation services.

10. If the employee who suffers an industrial illness or injury is appointed to a class at a lower salary level than his/her previous position, he/she shall be entitled to the pay step nearest to but no greater than his/her previous salary.

F. Supplemental Disability Payments

1. Any employee incapacitated by reason of a job-related illness or injury may be placed on an approved absence and may receive supplemental disability payments while under treatment and convalescing from such illness or injury in an amount as prescribed by the Memorandum of Understanding and/or Salary Resolution covering the classification.

2. Employees eligible for supplemental disability payments shall submit an "Application for Payment of Wages During Absence" (see exhibit at end of this section) for each pay period or as otherwise directed by their supervisor or the Worker's Compensation Section.

3. When the industrial illness or injury is of an intermittent or recurring nature, the City may continue to provide supplemental disability payments, provided that they do not exceed the limitations stated in (1) above.

4. Approved leave and supplementary disability payments may be terminated upon a determination by the Director of Human Resources that one or more of the following conditions exist:

   a. When it is determined that the injury is permanent and stationary.

   b. That the employee will not be able to return to work and perform those duties normally required for the job classification.

   c. The employee's return to work is approved by the Director of Human Resources

d. It is determined by the Director of Human Resources that the employee is not demonstrating a positive effort toward treatment and recuperation.

e. The employee fails to keep the Worker's Compensation Section apprised of his/her treatment schedule and medical progress as directed by the Worker's Compensation Coordinator.

f. The employee fails to provide specified medical reports from his/her treating doctor within a reasonable period of time.

g. The termination of temporary disability payments as prescribed by Worker's Compensation law.

h. The approved absence is terminated.

5. The Director of Human Resources may extend an approved leave and may authorize supplemental disability payments when it is administratively necessary to coordinate this provision with Worker's Compensation benefits.

G. Application for Payment of Wages

1. An Application for Payment of Wages must be submitted for all absences for which supplemental disability payments are requested. The Application must be submitted for each pay period unless other specific arrangements have been approved by the supervisor or the Worker's Compensation Section of Human Resources.

2. When an employee is seriously ill or injured and unable to prepare or sign the Application, the supervisor may verify the absence and submit the Application until the employee has recovered.

3. The department Payroll Clerks will have responsibility for ensuring that Applications for Payment of Wages (sick slip) have been received prior to posting on employee's time roll. All such Applications will be retained in the department files as verification of such absence.

H. Leave of Absence Without Pay

1. When an employee has exhausted all benefits and is still unable to return to regular duty, the employee may either be placed on a leave of absence without pay for a specific period of time or separated from City employment.

2. In the event a leave of absence without pay is granted, the following conditions shall apply:

   a. The employee will retain eligibility to compete in promotional examinations.

   b. The City will continue to pay the employee's personal health and dental insurance premium.

   c. In the event that more than one disabled employee may be available for the same position at the same time, the employee having the highest seniority in the class, or if this is equal, the one having the highest total seniority in the department shall be given preference.

   d. In the event the employee is reinstated to a position in a class other than his/her previous class after being on a leave of absence without pay, the employee shall be entitled to reinstatement of total seniority for purposes of future vacation and sick leave benefits, except that no retirement, sick leave or vacation benefits shall accrue for the period of the leave of absence without pay.

   e. If the employee has been unsuccessful in securing an appointment with the City during the leave period, the employee shall be separated from City employment.

I. Return from Disability Retirement/Vacation

Employees returning to an active pay status following a period of disability retirement shall receive a full vacation allotment for the first year of their return to work. The first year vacation allotment shall be consistent with the total number of years of active employment prior to the beginning of the disability retirement.

Regarding this first year allotment: In the event the employee again terminates within 12 months of the "return date" all pay for vacation taken by the employee shall accrue to the employee's credit. All time not taken and not earned shall revert back to the City, and no compensation shall be paid to the employee for unused vacation.

IV. Responsibility

A. The Worker's Compensation Section of the Human Resources Department is responsible for the administration and coordination of the overall Worker's Compensation program.

B. The Worker's Compensation Coordinator will control all medical services related to illness or injury. The Worker's Compensation Coordinator will notify the employee's department head, the Affirmative Action Department, and the Director of Human Resources whenever it is determined that an employee may not be physically able to return to his/her regular assignment for an extended period of time.

C. The Department of Finance will process all financial transactions related to the Worker's Compensation.

V. Appeals Board Hearing - Worker's Compensation

A. Purpose

To ensure that the interest of the employees and City are protected in all cases which are set for hearing before the Worker's Compensation Appeals Board.

B. Policy

1. Whenever appropriate, the Employee Relations Coordinator over the Worker's Compensation Section, the Worker's Compensation Coordinator and/or a representative and the department head or a representative shall attend the Worker's Compensation Appeals Board hearing.

2. Any and all information presented by the employee and/or their representative before the Appeals Board and including their current physical condition shall be used to evaluate their physical and mental capacity to return to their regular job or be retained by the City.

3. Employees may be subject to disciplinary action by the department head when found to be perjuring themselves before the Appeals Board.

4. In cases when the employee is medically cleared to return to work before the date of the hearing, it should be recognized by the supervisor that their work performance should be carefully reviewed and the degree of their recovery noted for consideration at the hearing.

5. In cases where substantial permanent disability ratings are made based upon the employee's claim that the ability to do their work has been impaired, the department head with the advice of the Department of Human Resources will evaluate the capability of the employee to continue in their present position.

6. Where employees continue to be employed by the City after permanent disability ratings are received, the case shall remain open and subject to subsequent review.

C. Procedure

1. Although not all inclusive, the following shall be used to prepare the City's case for a hearing:

   a. Before the hearing, time should be allowed by the Director of Human Resources and the department representative to consult with attorneys regarding the circumstances surrounding the case.

   b. All pertinent medical and employment information available should be reviewed in advance and be available at the hearing.

   c. It is important to review and prepare for each case in advance because it is difficult, if not impossible, for the City to obtain a continuance for any reason once a trial date is set.

   d. It is of the utmost importance that the supervisor obtain complete and factual information regarding the injury and record it fully and as promptly as possible following the injury.

   e. If there is any question on the part of anyone as to the validity of the claim by the employee, it should be reported to the department head and the Human Resources Department immediately, rather than waiting until the date of the hearing.

2. The City representatives shall not discuss the details of the cases with the employee prior to the hearing, unless specific information is requested and such information cleared through the City's legal representative, provided, however, that the Director of Human Resources and the Worker's Compensation Coordinator may advise on procedures to follow.

CITY OF PASADENA
APPLICATION FOR PAYMENT OF WAGES DURING ABSENCE

INSTRUCTIONS

EMPLOYEE

SICK LEAVE

1. An APPLICATION FOR PAYMENT (see below) must be submitted for *each pay period* in which sick leave was used.
2. For absence of less than 32 hrs. (Fire 48 hrs.), it is only necessary to complete the "APPLICATION FOR PAYMENT" (see below).
3. If absence is 32 hours or longer (Fire 48 hrs.), you *may not* receive benefits or return to work until the "APPLICATION FOR PAYMENT" and the "MEDICAL AUTHORIZATION" section (see reverse) is completed by your department, your attending physician, osteopath, chiropractor, or Christian Science practitioner *and* is approved by Risk Management. In extreme cases exceptions to the above may be approved by Risk Management with prior notice from your department.
   - A. Request your department to prepare a MEDICAL AUTHORIZATION (see reverse) for you prior to going to your physician.
   - B. Ask your physician to provide all applicable information on the MEDICAL AUTHORIZATION to avoid a delay in benefits or your return to work.

INDUSTRIAL

1. An APPLICATION FOR PAYMENT (see below) must be submitted for *each pay period* in which there is lost time because of work related injury or illness.
2. ALL APPLICATIONS FOR PAYMENT and or return to work must be approved by Risk Management *prior* to payment of benefits or your return to work.

DEPARTMENT

1. Contact employees who may be or have been absent 32 hours or longer (Fire 48 hrs.) and provide them with an APPLICATION FOR PAYMENT with the department section of the MEDICAL AUTHORIZATION completed (see reverse).
2. Instruct employees to have his/her attending physician complete the medical information requested. For prolonged absences or unusual circumstances, supervisors may certify to absence due to medical condition.
3. Have APPLICATION FOR PAYMENT approved by Risk Management.
4. Attach completed APPLICATION FOR PAYMENT to time card and send to Payroll. Payroll will return APPLICATION FOR PAYMENT to be maintained by the department.

APPLICATION FOR PAYMENT

EMPLOYEE ______________________ DEPARTMENT ______________ Injury Date: __________

I DO HEREBY CERTIFY THAT I WAS UNABLE TO WORK ON ACCOUNT OF ➡

I DO HEREBY REQUEST PAYMENT OF BENEFITS FOR THE FOLLOWING PERIOD:

______________, 19___ THRU ______________, 19___ ________ HOURS

HAS APPLICANT RETURNED TO WORK? YES_____ NO_____

EXPLAIN REASON FOR ABSENCE ______________________

	SICKNESS
	SICKNESS IN FAMILY
	BEREAVEMENT
	INDUSTRIAL INJURY WITH SUPPLEMENTAL PAY
	INDUSTRIAL INJURY *WITHOUT* SUPPLEMENTAL PAY
6	MONTH ENTITLEMENT
12	MONTH ENTITLEMENT

(CIRCLE ONE)

______________________ EMPLOYEE SIGNATURE ________ DATE

______________________ DEPARTMENT HEAD SIGNATURE ________ DATE ______________________ SUPERVISOR SIGNATURE ________ DATE

RISK MGT

IF ABSENCE IS 32 HOURS OR LONGER (FIRE 48) OR WORK RELATED, APPROVAL IS REQUIRED BY RISK MANAGEMENT.

APPROVED______ YES ______ NO ______________________ RISK MANAGEMENT ________ DATE

MEDICAL AUTHORIZATION

DEPARTMENT

COMPLETE INFORMATION BELOW AND GIVE TO EMPLOYEE TO BE TAKEN TO ATTENDING PHYSICIAN

Employee ______________________ Job Title ______________________

Department ______________________ Division ______________________ Phone Ext. __________

Normal Activities ______________________

Special Work Conditions ______________________

Modified Duty May be Available (Specify Type) ______________________

Date of Injury/Illness ______________________ Date Last Worked ______________________

____
Supervisor's or Foreman's Signature   Date

PHYSICIAN

YOUR COOPERATION IN PROVIDING THE INFORMATION REQUESTED WILL ASSIST THE CITY IN PROVIDING BENEFITS AND RETURNING YOUR PATIENT TO WORK
DOCTOR'S RETURN TO WORK SLIP IS ALSO ACCEPTABLE.

The Above-Named Employee has been under my care for present medical problem since ______________ (Date) *Last seen ______________ (Date)

*Brief Diagnosis ______________________

Brief Prognosis for Recovery ______________________

Surgery Performed (If Any) ______________________

Treatment (Medication, X-rays, Therapy, etc.) ______________________

Employee may Return to Normal Activities of Position on ______________ (Date)

Employee may Return to Modified Duty (If Available) on ______________ (Date)

Duration of Modified Duty ______________________

Restrictions (be specific) ______________________

Date of Next Appointment if Applicable ______________ Time ______________ Date

Physician's Address: ______________________ Phone ______________

*Must be Provided

____
Physician's Signature   Date

RISK MGT.

RISK AND GRANTS MANAGEMENT DEPARTMENT

Approval of Leave and/or Return to Work. Yes____ No____ By ______________________ Date

Remarks ______________________

STATE OF CALIFORNIA

EMPLOYEE — EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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

EMPLOYER

1. **CITY OF PASADENA**
2. 100 N. GARFIELD AVE. PASADENA, CALIFORNIA 91109
3. TELEPHONE (213) 577-4366
4. A MUNICIPAL GOVERNMENT LEGALLY UNINSURED
5. EMPLOYER NO. 0113

WRITE FIRMLY - YOU ARE MAKING FOUR COPIES

FORWARD ORIGINAL AND FIRST THREE COPIES TO RISK MANAGEMENT
- WHITE—CLAIMS
- CANARY—STATE OF CALIFORNIA
- PINK—LOSS CONTROL
- GREEN—COMPUTER
- GOLDENROD—DEPARTMENT

OSHA Case or File No.

California law requires an employer to report within five days every industrial injury or occupational disease which: (a) Results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. PLEASE NOTE: In addition, if death results or if the injury or illness: (a) Requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body: or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified immediately by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYEE

6. NAME
7. DATE OF BIRTH ___/___/___ (Month Day Year) AGE ______
8. HOME ADDRESS (Number and Street, City, Zip)
8A. PHONE NUMBER
9. SEX ☐ Male ☐ Female
10. OCCUPATION (regular job title, not specific activity at time of injury)
11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED
12A. DATE OF HIRE ___/___/___ (Month Day Year)
13. HOURS USUALLY WORKED — EMPLOYEE WORKS ______ HOURS PER DAY FOR ______ DAYS PER WEEK
13A. WEEKLY HOURS — WEIGHT — HEIGHT — MARITAL STATUS
14. GROSS WAGES/SALARY — EMPLOYEE EARNS $______ PER ☐ HOUR ☐ DAY ☐ WEEK ☐ EVERY TWO WEEKS — DRIVERS LICENSE NO.

INJURY OR ILLN

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (address, city and county)
15A. ON CITY PREMISES? ☐ Yes ☐ No
16. WHAT WERE YOU DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material you were using.)
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in cases of strains, the thing he was lifting, pulling, etc.)
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc.
19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.
20. NAME AND ADDRESS OF PHYSICIAN
21. IF HOSPITALIZED, NAME OF HOSPITAL — BED PATIENT — EMERGENCY ONLY
22. DATE OF INJURY OR ILLNESS ___/___/___ (Month Day Year)
23. TIME OF DAY ______ a.m. ______ p.m.
24. Did employee lose at least one full day's work after the injury? ☐ Yes, date last worked ______ ☐ No

SUPERVISOR

25. HAS EMPLOYEE RETURNED TO WORK? ☐ Yes, date returned ______ ☐ No, still off work
26. DID EMPLOYEE DIE? ☐ No ☐ Yes, date ______

I HAVE THOROUGHLY INVESTIGATED THE ABOVE INCIDENT. YES ☐ NO ☐

THE INFORMATION AS GIVEN IS COMPLETE AND CORRECT. YES ☐ NO ☐

IMMEDIATE SUPERVISOR: YOU MUST FILL OUT AND ACCOMPANY THIS REPORT WITH THE "SUPERVISORS ACCIDENT INVESTIGATION REPORT" (LOSS CONTROL FORM LC-5-3-200)

SIGNATURE OF IMMEDIATE SUPERVISOR — TITLE — TELEPHONE — DATE

WITNESS NAME — ADDRESS — TELEPHONE NO.

WAS ANOTHER PERSON RESPONSIBLE FOR YOUR INJURY OR ILLNESS? IF SO, GIVE NAME, ADDRESS, TELEPHONE, DRIVERS LICENSE

COULD YOU OR YOUR SUPERVISOR HAVE DONE ANYTHING TO PREVENT INJURY? IF SO, PLEASE EXPLAIN.

DATE INJURY REPORTED TO SUPERVISOR — TIME ☐ A.M. ☐ P.M.

ARE YOU ENGAGED IN ANY TYPE OF WORK, EMPLOYMENT OR ENTERPRISE OTHER THAN YOUR JOB WITH THE CITY? YES ☐ NO ☐ — IF "YES", ON A SEPARATE SHEET STATE NAME AND ADDRESS OF EMPLOYERS, TYPE OF WORK, POSITION AND DATE LAST WORKED.

— EMPLOYEE'S STATEMENT: I certify that all statements in this report are true and I agree and understand that any misstatement or omission of a material fact herein may constitute cause for dismissal from any employment in the service of the City of Pasadena.

— I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION REGARDING THIS INJURY OR ILLNESS TO REPRESENTATIVES OF THE CITY.

EMPLOYEE'S SIGNATURE — DATE

Form 5020 (Rev. 5) September, 1983

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

PLEASE D[O NOT] USE THIS C[OLUMN]
- CASE
- OWNER
- INDUST
- OCCUPA
- SEX
- AGE
- DAILY HO
- DAYS PER
- WEEKLY H
- WEEKLY W
- COUNT
- NATURE OF I
- PART OF B
- SOURC
- ACCIDENT
- A.O.S.
- EXTENT OF I
- CODED

Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

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

EMPLOYEE:

1. Name ______________________ Today's Date ______________
2. Home Address ______________________
3. City ______________ State ________ Zip ____________
4. Date of Injury ______________ Time of Injury __________ ______ a.m. _____ p.m.
5. Address/Place where injury happened ______________________
6. Describe injury and part of body affected ______________________
7. Signature of employee ______________________

EMPLOYER: *COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.*

8. Name and address of employer City of Pasadena
   100 N. Garfield Ave., Pasadena, California 91109
9. Date employer first knew of injury ______________________
10. Date claim form was provided to employee ______________________
11. Date employer received claim form ______________________
12. Name and address of insurance carrier or adjusting agency Self-Administered and Self-Insured
13. Signature of Employer Representative ______________________
14. Title ______________________ 15. Telephone (818) 405-4379

EMPLOYER: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

TO BE COMPLETED WITHIN 24 HOURS OF THE INJURY

CITY OF PASADENA
SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

FORWARD ORIGINAL AND FIRST COPY TO RISK MANAGEMENT
WHITE — CLAIMS
CANARY — LOSS CONTROL
PINK — DEPARTMENT

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

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

DESCRIPTION

DESCRIBE CLEARLY HOW THE ACCIDENT OCCURRED

ANALYSIS

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

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

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

PREVENTION

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

☐ LOST TIME

☐ NO LOST TIME

I HAVE REVIEWED THE EMPLOYEE'S STATEMENT AND INVESTIGATED THIS MATTER

☐ I KNOW THIS INJURY OCCURRED ON-DUTY

☐ I HAVE NO SPECIFIC KNOWLEDGE THAT THIS INJURY OCCURRED ON-DUTY

SIGNATURE OF IMMEDIATE SUPERVISOR	DATE	SIGNATURE OF SUPERINTENDENT	DATE

ADMINISTRATIVE REVIEW — RISK MANAGEMENT

☐ WORKER'S COMPENSATION BENEFITS AUTHORIZED

☐ WORKER'S COMPENSATION BENEFITS DENIED

COMMENTS ______

REVIEWED BY ______ DATE ______