

The Division of Labor Standards Enforcement believes that the sample posting below meets the requirements of Labor Code Section 1102.8(a). This document must be printed to 8.5 x 14 inch paper with margins no larger than one-half inch in order to conform to the statutory requirement that the lettering be larger than size 14 point type.

## **WHISTLEBLOWERS ARE PROTECTED**

It is the public policy of the State of California to encourage employees to notify an appropriate government or law enforcement agency, person with authority over the employee, or another employee with authority to investigate, discover, or correct the violation or noncompliance, and to provide information to and testify before a public body conducting an investigation, hearing or inquiry, when they have reason to believe their employer is violating a state or federal statute, or violating or not complying with a local, state or federal rule or regulation.

### **Who is protected?**

Pursuant to [California Labor Code Section 1102.5](#), employees are the protected class of individuals. "Employee" means any person employed by an employer, private or public, including, but not limited to, individuals employed by the state or any subdivision thereof, any county, city, city and county, including any charter city or county, and any school district, community college district, municipal or public corporation, political subdivision, or the University of California. [[California Labor Code Section 1106](#)]

### **What is a whistleblower?**

A "whistleblower" is an employee who discloses information to a government or law enforcement agency, person with authority over the employee, or to another employee with authority to investigate, discover, or correct the violation or noncompliance, or who provides information to or testifies before a public body conducting an investigation, hearing or inquiry, where the employee has reasonable cause to believe that the information discloses:

1. A violation of a state or federal statute,
2. A violation or noncompliance with a local, state or federal rule or regulation, or
3. With reference to employee safety or health, unsafe working conditions or work practices in the employee's employment or place of employment.

A whistleblower can also be an employee who refuses to participate in an activity that would result in a violation of a state or federal statute, or a violation of or noncompliance with a local, state or federal rule or regulation.

### **What protections are afforded to whistleblowers?**

1. An employer may not make, adopt, or enforce any rule, regulation, or policy preventing an employee from being a whistleblower.
2. An employer may not retaliate against an employee who is a whistleblower.
3. An employer may not retaliate against an employee for refusing to participate in an activity that would result in a violation of a state or federal statute, or a violation or noncompliance with a state or federal rule or regulation.
4. An employer may not retaliate against an employee for having exercised his or her rights as a whistleblower in any former employment.

Under [California Labor Code Section 1102.5](#), if an employer retaliates against a whistleblower, the employer may be required to reinstate the employee's employment and work benefits, pay lost wages, and take other steps necessary to comply with the law.

### **How to report improper acts**

If you have information regarding possible violations of state or federal statutes, rules, or regulations, or violations of fiduciary responsibility by a corporation or limited liability company to its shareholders, investors, or employees, **call the California State Attorney General's Whistleblower Hotline at 1-800-952-5225**. The Attorney General will refer your call to the appropriate government authority for review and possible investigation.



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

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file 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 you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

**Medical Care:** Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

**The Primary Treating Physician (PTP)** is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to \$10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

### **Switching to a Different Doctor as Your PTP:**

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, el administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

**Atención Médica:** Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

**El Médico Primario que le Atiende (Primary Treating Physician- PTP)** es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN*) o una Organización de Cuidado Médico (*Health Care Organization- HCO*), en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta \$10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

### **Cambiando a otro Médico Primario o PTP:**

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

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

**Problems with Medical Care and Medical Reports:** At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

**Payment for Temporary Disability (Lost Wages):** If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. 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.

**Stay at Work or Return to Work:** Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

**Payment for Permanent Disability:** If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

**Supplemental Job Displacement Benefit (SJDB):** If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

**Death Benefits:** If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

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

**Problemas con la Atención Médica y los Informes Médicos:** En algún momento durante su reclamo, podría estar en desacuerdo con su PTP sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una MPN, HCO o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su PTP, puede solicitar una revisión médica independiente (*Independent Medical Review-IMR*), utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la IMR es parecido al proceso de la IMR de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la IMR. La IMR no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su PTP en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesga perder el derecho a objetar a la opinión de su PTP a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado (*Qualified Medical Evaluator-QME*) para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado (*Agreed Medical Evaluator- AME*). Si el administrador de reclamos no está de acuerdo con su PTP sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un QME o AME.

**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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de 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 una noche o no puede trabajar durante más de 14 días.

**Permanezca en el Trabajo o Regreso al Trabajo:** Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other 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.

**Resolving Problems or Disputes:** You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or 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) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at [www.edd.ca.gov](http://www.edd.ca.gov).

**You Can Contact an Information & Assistance (I&A) Officer:** State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

**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 website at [www.californiaspecialist.org](http://www.californiaspecialist.org).

**Learn More About Workers' Compensation:** For more information about the workers' compensation claims process, go to [www.dwc.ca.gov](http://www.dwc.ca.gov). At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

**Pago por Incapacidad Permanente:** Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

**Beneficio Suplementario por Desplazamiento de Trabajo (Supplemental Job Displacement Benefit- SJDDB):** Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisitos, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

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

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

**Resolviendo problemas o disputas:** Ud. tiene derecho a no estar de acuerdo con las decisiones que afectan su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (*State Disability Insurance- SDI*) o beneficios del desempleo (*Unemployment Insurance- UI*). Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en [www.edd.ca.gov](http://www.edd.ca.gov).

**Puede Contactar a un Oficial de Información y Asistencia (Information & Assistance- I&A):** Los Oficiales de Información y Asistencia (*I&A*) estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a [www.dwc.ca.gov](http://www.dwc.ca.gov) o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

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

**Aprenda Más Sobre la Compensación de Trabajadores:** Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a [www.dwc.ca.gov](http://www.dwc.ca.gov). En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.



**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

**PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)**

**Employee:** Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**Empleado:** Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al **(800) 736-7401** para oír información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

**Employee—complete this section and see note above**

**Empleado—complete esta sección y note la notación arriba.**

1. Name. *Nombre.* \_\_\_\_\_ 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 ocurrió el accidente.* \_\_\_\_\_
  6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* \_\_\_\_\_
  7. Social Security Number. *Número de Seguro Social del Empleado.* \_\_\_\_\_
  8. ☐ Check if you agree to receive notices about your claim by email only. ☐ Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. Employee's e-mail. \_\_\_\_\_ Correo electrónico del empleado. \_\_\_\_\_
- You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* \_\_\_\_\_

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

10. Name of employer. *Nombre del empleador.* \_\_\_\_\_
11. Address. *Dirección.* \_\_\_\_\_
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* \_\_\_\_\_
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* \_\_\_\_\_
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_
16. Insurance Policy Number. *El número de la póliza de Seguro.* \_\_\_\_\_
17. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
18. Title. *Título.* \_\_\_\_\_ 19. 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



Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

**Benefits.** Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

**Naming Your Own Physician Before Injury or Illness (Predesignation).** You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group *before* you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

**If You Get Hurt:**

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
  - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
  - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
  - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: www.peiwc.com

MPN Effective Date: PEI 5/08 StarNet 1/13      MPN Identification number: PEI (1226) / StarNet (2087)

If you need help locating an MPN physician, call your MPN access assistant at: (888) 799-6477

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: (888) 472-9001

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

**Questions?** Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator Preferred Employers Insurance Company      Phone (888) 472-9001

Workers' compensation insurer Preferred Employers Insurance Company (Enter "self-insured" if appropriate)

You can also get free information from a State Division of Workers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: \_\_\_\_\_ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: [www.dwc.ca.gov](http://www.dwc.ca.gov) and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured Workers."

**False claims and false denials.** 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.



Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

**Beneficios.** Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

**Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa).** Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

**Si Usted se Lastima:**

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
  - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
  - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
  - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN :

Página web de la MPN: www.peiwc.com

Fecha de vigencia de la MPN: PEI 5/08 StarNet 1/13      Número de identificación de la MPN: PEI (1226) / StarNet (2987)

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: (888) 799-6477

Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: (888) 472-9001

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

**¿Preguntas?** Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos Preferred Employers Insurance Company      Teléfono (888) 472-9001

Asegurador del Seguro de Compensación de trabajador Preferred Employers Insurance Company (Anoté “autoasegurado” si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: \_\_\_\_\_ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil “Compensación del Trabajador de California Una Guía para Trabajadores Lesionados.”

**Los reclamos falsos y rechazos falsos del reclamo.** Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| State of California<br><b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                    | Please complete in triplicate (type if possible) Mail two copies to:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | OSHA CASE NO.                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | FATALITY <input type="checkbox"/>                                                                                                                                          |  |
| Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                    | California law requires employers to report within <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be <b>reported immediately</b> by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health. |  |                                                                                                                                                                            |  |
| EMPLOYER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. FIRM NAME                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 1a. Policy Number                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2. MAILING ADDRESS: (Number, Street, City, Zip)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 2a. Phone Number                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3. LOCATION if different from Mailing Address (Number, Street, City and Zip)                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3a. Location Code                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. State unemployment insurance acct.no                                                                                                                                    |  |
| INJURY OR ILLNESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | INDUSTRY                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. DATE LAST WORKED (mm/dd/yy)                                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 13. DATE RETURNED TO WORK (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | AGE                                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20a. COUNTY                                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DAILY HOURS                                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DAYS PER WEEK                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | WEEKLY HOURS                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | WEEKLY WAGE                                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 27. Name and address of physician (number, street, city, zip)                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 27a. Phone Number                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes then, name and address of hospital (number, street, city, zip)                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. Phone Number                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | PART OF BODY                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.<br>Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | SOURCE                                                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30. EMPLOYEE NAME                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 31. SOCIAL SECURITY NUMBER                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 32. DATE OF BIRTH (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | EVENT                                                                                                                                                                      |  |
| EMPLOYEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 33. HOME ADDRESS (Number, Street, City, Zip)                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 33a. PHONE NUMBER                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 36. DATE OF HIRE (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | SECONDARY SOURCE                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 38. GROSS WAGES/SALARY \$ _____ per _____                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | EXTENT OF INJURY                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Completed By (type or print)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Signature & Title                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Date (mm/dd/yy)                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                            |  |
| * Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies. |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                            |  |

# MPN Employer Acknowledgement Letter

The MPN regulations are silent about Employee Acknowledgement Letters. As an employer, you have the right to use acknowledgement letters for your employees to sign when you give your employee the Full Written MPN Notification.

**California Medical Provider Network (MPN)  
Acknowledgement Form**

I have received the information that tells me how to obtain medical care within the

Preferred Select MPN

\_\_\_\_\_  
(Name of MPN)

I understand that if medical care is needed for a work-related injury I must be treated by an approved doctor to qualify for benefits. Approved doctors are either a physician in the Medical Provider Network or my predesignated personal physician.

In case of an emergency, I understand that I should call 911 or go to the closest emergency room.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

I live at \_\_\_\_\_  
(Street Address)

\_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

Name of Employer \_\_\_\_\_

|                                                                                                         |
|---------------------------------------------------------------------------------------------------------|
| <p><b>Important Information about Medical Care if You Have a<br/>Work-Related Injury or Illness</b></p> |
|---------------------------------------------------------------------------------------------------------|

**Complete Written Employee Notification Re: Medical Provider Network**

(Title 8, California Code of Regulations, section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer, has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Preferred Employers Insurance Company.

This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

- **What happens if I get injured at work?**

**In case of an emergency, you should call 911 or go to the closest emergency room.**

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

- **What is an MPN?**

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by your employer to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

- **What MPN is used by my employer?**

Your employer is using the Preferred Select MPN with the identification number 1226. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

- **Who can I contact if I have questions about my MPN?**

The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

The contact for your MPN is:

Name: Preferred Employers Insurance Company

Title: Preferred Select MPN Contact

Address: P.O. Box 85838, San Diego, CA 92186-5838

Telephone Number: (866) 472-9001

Email address: [mpn@peiwc.com](mailto:mpn@peiwc.com)

General information regarding the MPN can also be found at the following website:  
[www.peiwc.com](http://www.peiwc.com)

- **What if I need help finding and making an appointment with a doctor?**

## **Preferred Employers Insurance Company – Preferred Select MPN**

The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours.

Assistance is available in English and in Spanish.

The contact information for the Medical Access Assistant is:

Toll Free Telephone Number: (888) 799-6477

Fax Number: (866) 326-1335

Email Address: [mpn@peiwc.com](mailto:mpn@peiwc.com)

### **How do I find out which doctors are in my MPN?**

You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: [www.peiwc.com](http://www.peiwc.com) and click on "Find a Doctor". At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

You can access the roster of all treating physicians in the MPN by going to the website at [www.peiwc.com](http://www.peiwc.com), click on "Find a Doctor", click on "Search Providers", under "By Region" select "CA" from the drop down menu. A link will appear to the right entitled "CA MPN Roster of Treating Physicians". Click on this link to access the full roster of all treating physicians in the MPN.

- **How do I choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with a MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire state of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The

## **Preferred Employers Insurance Company – Preferred Select MPN**

MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

- **What if I need a specialist that is not available in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second-opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

|                                                                                                         |
|---------------------------------------------------------------------------------------------------------|
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**In case of an emergency, you should call 911 or go to the closest emergency room.**

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The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours.

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- **How do I choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with a MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire state of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The

## **Preferred Employers Insurance Company – Preferred Select MPN**

MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

- **What if I need a specialist that is not available in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second-opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

## **Preferred Employers Insurance Company – Preferred Select MPN**

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

- **What if I am already being treated for a work-related injury before the MPN begins?**

Preferred Employers Insurance Company has a “*Transfer of Care*” policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If Preferred Employers Insurance Company decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

***Can I Continue Being Treated By My Doctor?***

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with Preferred Employers decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, Preferred Employers Insurance Company can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer or Preferred Employers Insurance Company if you wish to postpone the transfer of your care. If you or your employer, or Preferred Employers Insurance Company disagrees with your doctor's report on your condition, you or your employer, or Preferred Employers Insurance Company can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

• **What if I am being treated by a MPN doctor who decides to leave the MPN?**

Preferred Employers Insurance Company has a written "*Continuity of Care*" policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If Preferred Employers Insurance Company decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the "***Can I Continue Being Treated By My Doctor?***" box above.

## Preferred Employers Insurance Company – Preferred Select MPN

You can disagree with Preferred Employers Insurance Company's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, Preferred Employers Insurance Company's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to Preferred Employers Insurance Company if you wish to postpone the selection of a MPN doctor treatment for your continued treatment. If you or Preferred Employers Insurance Company disagrees with your doctor's report on your condition, you or Preferred Employers Insurance Company can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I have questions or need help?**

- **MPN Contact:** You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.
- **Medical Access Assistants:** You can contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.
- **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at [www.dir.ca.gov/dwc](http://www.dir.ca.gov/dwc) and click on "medical provider networks" for more information about MPNs.
- **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

DWC Medical Unit  
P.O. Box 71010  
Oakland, CA 94612  
(510) 286-3700 or (800) 794-6900

|                                                                                 |
|---------------------------------------------------------------------------------|
| <b>Keep this information in case you have a work-related injury or illness.</b> |
|---------------------------------------------------------------------------------|

## **Información importante sobre la atención médica si usted sufre una lesión o enfermedad relacionada con el trabajo**

### **Notificación escrita completa del empleado**

#### **Re: Red de proveedores médicos**

(Título 8, Código de Reglamentaciones de California, artículo 9767.12)

Las leyes de California requieren que su empleador brinde y pague el tratamiento médico si usted sufre una lesión en el trabajo. Su empleador eligió ofrecerle esta atención médica mediante una red de médicos del seguro de riesgos del trabajo denominada “red de proveedores médicos” (MPN, por su sigla en inglés). Preferred Employers Insurance Company es la administradora de esta MPN.

La presente notificación le informa lo que tiene que saber sobre el programa de la MPN y describe sus derechos a la hora de elegir la atención médica para las lesiones y enfermedades relacionadas con el trabajo.

- **¿Qué ocurre si me lesiono en el trabajo?**

En caso de emergencia, llame al 911 o diríjase a la sala de primeros auxilios más cercana. Si usted sufre una lesión en el trabajo, notifíquese a su empleador lo antes posible. Su empleador le proporcionará un formulario de reclamo. Cuando le notifique a su empleador que sufrió una lesión relacionada con el trabajo, su empleador o asegurador le dará una cita inicial con un médico de la MPN.

- **¿Qué es una MPN?**

Una red de proveedores médicos es un grupo de profesionales de la salud (médicos y otros proveedores) utilizado por su empleador para el tratamiento de los trabajadores que sufran lesiones en el trabajo. Las MPN deben darles a los empleados la posibilidad de elegir entre distintos proveedores. Cada MPN debe incluir una combinación de médicos especializados en lesiones relacionadas con el trabajo y médicos especializados en áreas generales de la medicina.

- **¿Qué MPN usa mi empleador?**

Su empleador usa la MPN Preferred Select, cuyo número de identificación es 1226. Si tiene preguntas o solicitudes referidas a la MPN, deberá mencionar el nombre y el número de identificación de la MPN.

- **¿Con quién debo ponerme en contacto si tengo alguna pregunta sobre mi MPN?**

El contacto de la MPN que aparece en esta notificación podrá responder sus preguntas sobre el uso de la MPN y se ocupará de las quejas relacionadas con la MPN.

El contacto de su MPN es:

Nombre: Preferred Employers Insurance Company  
Cargo: Contacto de la MPN Preferred Select  
Dirección: P.O. Box 85838, San Diego, CA 92186-5838

## **Preferred Employers Insurance Company – Preferred Select MPN**

Número de teléfono: (866) 472-9001

Dirección de correo electrónico: [mpn@peiwc.com](mailto:mpn@peiwc.com)

La información general relacionada con la MPN también se encuentra en el siguiente sitio web: [www.peiwc.com](http://www.peiwc.com)

- **¿Qué debo hacer si necesito ayuda para encontrar y realizar una cita con un médico?**

El asistente de acceso médico de la MPN lo/la ayudará a encontrar los médicos de la MPN que se encuentren disponibles y lo/la ayudará a realizar la cita y confirmarla. El asistente de acceso médico se encuentra disponible para asistirlo/a de lunes a sábado desde las 7:00 am hasta las 8:00 pm, horario del Pacífico, y programar las citas médicas durante el horario normal de trabajo de los médicos. La asistencia se encuentra disponible tanto en inglés como en español.

La información de contacto del asistente de acceso médico es:

Número de llamada gratuita: (888) 799-6477

Número de fax: (866) 326-1335

Dirección de correo electrónico: [mpn@peiwc.com](mailto:mpn@peiwc.com)

- **¿Cómo encuentro a los médicos que forman parte de mi MPN?**

Puede obtener una lista regional de todos los proveedores de la MPN de su área llamando al contacto de la MPN o en nuestro sitio web en: [www.peiwc.com](http://www.peiwc.com) y pulse "Find a Doctor" (buscar un médico). Como mínimo, la lista regional deberá incluir una lista de todos los proveedores de la MPN en un radio de 15 millas de su lugar de trabajo y/o residencia o una lista de todos los proveedores de la MPN del condado en el que vive y/o trabaja. Puede elegir qué lista recibir. También tiene derecho a solicitar una lista de todos los proveedores de la MPN.

Usted podrá acceder la lista de médicos tratantes dentro de la red MPN visitando la página web [www.peiwc.com](http://www.peiwc.com). Dele click en "Find a Doctor", después dele click en "Search Providers"; bajo la opción "By Region" seleccione "CA" en el menú de en medio.

Una liga aparecerá en el lado derecho titulado "CA MPN Roster of Treating Physicians". Dele click a esta liga para acceder la lista completa de todos los médicos tratantes dentro de la MPN.

- **¿Cómo elijo a un proveedor?**

Su empleador o la compañía de seguros de su empleador harán los arreglos necesarios para la realización de la evaluación médica inicial con un médico de la MPN. Después de la primera visita médica, podrá continuar tratándose con ese médico o podrá elegir a otro médico de la MPN. Podrá continuar eligiendo médicos de la MPN para todas las instancias de atención médica relacionadas con esta lesión.

De resultar apropiado, podrá elegir a un especialista o solicitarle a su médico tratante que lo derive a otro especialista. Algunos especialistas solo aceptan citas mediante la derivación de un médico tratante. Ese especialista aparecerá en la guía de la MPN con la leyenda "solo por derivación".

Si precisa ayuda para encontrar a un médico o programar una cita, comuníquese con el asistente de acceso médico.

- **¿Puedo cambiar de proveedor?**

## **Preferred Employers Insurance Company – Preferred Select MPN**

Sí. Puede cambiar de proveedor dentro de la MPN por cualquier razón, pero los proveedores que elija deben ser apropiados para el tratamiento de su lesión. Comuníquese con el contacto de la MPN o con su liquidador de siniestros si desea modificar a su médico tratante.

- **¿Qué normas debe cumplir la MPN?**

La MPN cuenta con proveedores para los siguientes para todo el estado de California.

La MPN deberá darle acceso a una lista regional de proveedores que incluya al menos a tres médicos de cada especialidad usados comúnmente para tratar las lesiones o enfermedades de su sector. La MPN deberá darles acceso a médicos de cabecera dentro de los 30 minutos y en un radio de 15 millas y, en el caso de los especialistas, dentro de los 60 minutos y en un radio de 30 millas del lugar en el que viva o trabaje.

Si usted vive en una zona rural o un área en la que la atención médica es escasa, es posible que se aplique otra norma.

Una vez que le haya notificado la lesión a su empleador, la MPN deberá brindar el tratamiento inicial dentro de los tres días hábiles posteriores. Si se autorizó el tratamiento con un especialista, la cita con el especialista deberá darse dentro de los 20 días hábiles posteriores a su solicitud.

Si tiene problemas para obtener una cita con un proveedor de la MPN, póngase en contacto con el asistente de acceso médico.

Si no hay proveedores de la MPN de la especialidad pertinente que estén disponibles para tratar su lesión según los requisitos de distancia y tiempo, entonces usted podrá buscar dónde tratarse fuera de la MPN.

- **¿Qué ocurre si no hay proveedores de la MPN en el lugar en el que me encuentro?**

Si en la actualidad usted es empleado/a y vive en una zona rural o se encuentra trabajando o viviendo temporariamente fuera del área de servicio de la MPN, la MPN o su médico tratante le darán una lista de al menos tres médicos que puedan tratarlo/a. También es posible que la MPN le permita elegir a su médico fuera de la red de la MPN. Comuníquese con su contacto de la MPN si necesita ayuda para encontrar un médico y desea obtener más información.

- **¿Qué debo hacer si necesito un especialista que no se encuentra disponible en la MPN?**

Si necesita consultar a un tipo de especialista que no se encuentra disponible en la MPN, tiene derecho a ver al especialista fuera de la MPN.

- **¿Y si no me pongo de acuerdo con el médico respecto del tratamiento médico?**

## **Preferred Employers Insurance Company – Preferred Select MPN**

Si usted no llega a un acuerdo con su médico o desea cambiar de médico por alguna razón, podrá elegir a otro médico dentro de la MPN.

Si usted está en desacuerdo con el diagnóstico o tratamiento indicado por su médico, podrá solicitar una segunda opinión de otro médico dentro de la MPN. Si desea una segunda opinión, comuníquese con el contacto de la MPN o el liquidador de siniestros y hágales saber que desea una segunda opinión. La MPN debería proporcionarle al menos una lista de proveedores de la MPN completa o regional para que usted elija un médico que le dé una segunda opinión. Para obtener una segunda opinión deberá elegir a un médico de la lista de la MPN y pedir una cita dentro de los 60 días posteriores. Deberá informarle la fecha de la cita al contacto de la MPN y la MPN le mandará al médico una copia de su historia clínica. Puede solicitar una copia de la historia médica que le será enviada al médico.

Si no realiza la cita dentro de los 60 días posteriores a la recepción de la lista de proveedores regionales, no se le permitirá consultar a un segundo o tercer médico en relación con el diagnóstico o el tratamiento en discusión realizado por el médico tratante.

Si el segundo médico considera que su lesión no forma parte del tipo de lesiones que él/ella trata normalmente, el consultorio médico se lo notificará a su empleador o compañía de seguros y a usted. Recibirá otra lista de médicos y especialistas de la MPN para poder realizar una nueva selección.

Si está en desacuerdo con la segunda opinión, puede solicitar una tercera. Si pide una tercera opinión, deberá realizar el mismo proceso que para la segunda.

Tenga en cuenta que, si no realiza la cita dentro de los 60 días posteriores a la obtención de otra lista de la MNP, no se le permitirá consultar a un tercer médico en relación con el diagnóstico o el tratamiento en discusión realizado por el médico tratante.

Si está en desacuerdo con la opinión del tercer médico, puede solicitar una **evaluación médica independiente de la MNP**. Su empleador o contacto de la MNP le dará información sobre la forma de solicitar la evaluación médica independiente en el momento en el que elija al tercer médico.

Si el segundo o tercer médico o el evaluador médico independiente está de acuerdo con que es necesario que usted se someta a un tratamiento o estudio, se le permitirá recibir ese servicio médico de un proveedor de dentro de la MPN o, si la MPN no cuenta con un médico que pueda brindar el tratamiento recomendado, podrá elegir a un médico de fuera de la MPN siempre que se encuentre dentro de un área geográfica razonable.

- **¿Qué ocurre si ya me están tratando por una lesión relacionada con el trabajo antes de que comience la MNP?**

Preferred Employers Insurance Company cuenta con una política de “Transferencia de la atención”, que determinará si un médico de fuera de la MPN puede continuar tratándolo por una lesión existente relacionada con el trabajo antes de transferir su atención a la MPN.

Si el médico que lo/la atiende en la actualidad no es miembro de la MPN, entonces se le podrá solicitar que se trate con un médico de la MPN. Sin embargo, si cuenta con un médico tratante de cabecera previamente asignado adecuadamente, no podrá transferirse a la MPN. (Si tiene alguna consulta sobre la asignación previa, hable con su supervisor).

## Preferred Employers Insurance Company – Preferred Select MPN

Si Preferred Employers Insurance Company decide transferirlo a la MPN, usted y su médico tratante de cabecera deberán recibir una carta de notificación de la transferencia.

Si cumple ciertas condiciones, será elegible para continuar su tratamiento con un médico que no pertenezca a la MPN durante un período de un año como máximo antes de transferirse a la MPN. Las condiciones de elegibilidad para posponer la transferencia de su atención a la MPN se consignan a continuación.

### ***¿Mi médico puede continuar tratándome?***

Es posible que sea elegible para continuar su tratamiento con un proveedor que no pertenezca a la MPN (por medio de la transferencia de la atención o la continuidad de la atención) durante un período máximo de un año si su lesión o enfermedad cumple **cualquiera** de las siguientes condiciones:

- **(Aguda)** El tratamiento de su lesión o enfermedad terminará en menos de 90 días.
- **(Seria o crónica)** Su lesión o enfermedad es seria y se extiende durante al menos 90 días sin que se llegue a una cura definitiva o se empeora y requiere continuar con el tratamiento. Es posible que le sea permitido continuar el tratamiento con su médico tratante actual durante un período máximo de un año hasta que se pueda transferir la atención sin riesgos.
- **(Terminal)** Usted tiene una lesión o padece una enfermedad irreversible que probablemente le cause la muerte dentro de un período máximo de 1 año.
- **(Cirugía pendiente)** Usted ya tiene programada una cirugía u otro procedimiento que fue autorizado por su empleador o compañía de seguros y que tendrá lugar dentro de los 180 días posteriores a la fecha de vigencia de la MPN o del vencimiento del contrato entre la MPN y su médico.

Usted puede estar en desacuerdo con la decisión de Preferred Employers de transferir su atención médica a la MPN. Si no desea que lo/la transfieran a la MPN, solicítele a su médico tratante de cabecera un informe médico en el que establezca si usted tiene alguna de las cuatro condiciones anteriores para que se posponga su transferencia a la MPN.

Su médico tratante de cabecera tiene 20 días a partir de la fecha de su solicitud para darle una copia del informe de su estado de salud. Si su médico tratante de cabecera no le da el informe dentro de los 20 días de la solicitud, Preferred Employers Insurance Company puede transferir su atención a la MPN y usted deberá utilizar a un médico de la MPN.

Usted deberá proporcionarle una copia del informe a su empleador si desea posponer la transferencia de la atención. Si usted o Preferred Employers Insurance Company están en desacuerdo con el informe de su médico respecto de su enfermedad, usted o su empleador podrán cuestionarlo. Consulte la política sobre "Transferencia de la atención" completa si desea más detalles sobre el proceso de resolución de disputas.

Si desea una copia de la política de "Transferencia de la atención" en inglés o español, solicítesela a su contacto de la MPN.

- **¿Qué ocurrirá si decido tratarme con un médico de la MPN que decide dejar la MPN?**

## Preferred Employers Insurance Company – Preferred Select MPN

Preferred Employers Insurance Company cuenta con una política de "Continuidad de la atención" escrita que determinará si usted puede continuar temporariamente con el tratamiento de una lesión relacionada con el trabajo existente con su médico si este ya no forma parte de la MPN.

Si su empleador decide que usted ya no es elegible para continuar con su atención con el proveedor que no pertenece a la MPN, usted y su médico tratante de cabecera deberán recibir una carta en la que se los notifique de esta decisión.

Si usted cumple ciertas condiciones, será elegible para continuar su tratamiento con un médico durante un período de un año como máximo antes de verse obligado a elegir a un médico de la MPN. Estas condiciones se encuentran en el cuadro "¿Mi médico puede continuar tratándome?" anterior.

Usted puede estar en desacuerdo con la decisión de Preferred Employers Insurance Company de denegarle la continuidad de la atención con el proveedor de la MPN que dejó la red. Si usted desea continuar tratándose con este médico, solicítele al médico tratante de cabecera un informe médico sobre si usted cumple con una de las cuatro condiciones incluidas en el cuadro anterior para determinar si es elegible para continuar tratándose con su médico actual de manera temporaria.

Su médico tratante de cabecera tiene 20 días a partir de la fecha de su solicitud para darle su copia del informe sobre su estado de salud. Si su médico tratante de cabecera no le proporciona el informe dentro de los 20 días posteriores a la solicitud, se aplicará la decisión de Preferred Employers Insurance Company de denegarle la continuidad de la atención con su médico que ya no participa en la MPN y usted deberá elegir a un médico de la MPN.

Usted deberá proporcionarle una copia del informe a Preferred Employers Insurance Company si desea posponer la elección de un tratamiento con un médico de la MPN. Si usted o Preferred Employers Insurance Company están en desacuerdo con el informe de su médico respecto de su enfermedad, usted o Preferred Employers Insurance Company podrán cuestionarlo. Consulte la política sobre "Continuidad de la atención" completa si desea más detalles sobre el proceso de resolución de disputas.

Si desea una copia de la política de "Continuidad de la atención" en inglés o español, solicítesela a su contacto de la MPN.

- **¿Adónde me dirijo si tengo preguntas o necesito ayuda?**

- **Contacto de la MPN:** Siempre puede comunicarse con el contacto de la MPN si tiene preguntas sobre el uso de la MPN y para hacerle llegar sus quejas respecto de la MPN.
- **Asistentes de acceso médico:** Puede ponerse en contacto con el asistente de acceso médico si necesita ayuda para buscar a médicos de la MPN y para programar y confirmar citas.
- **División de Indemnización al Trabajador (DWC, por su sigla en inglés):** Si tiene alguna inquietud, queja o consulta sobre la MPN, el proceso de notificación o su tratamiento médico después de una lesión o enfermedad relacionada con el trabajo, llame a la oficina de Información y Asistencia de la DWC al 1-800-736-7401. También

## **Preferred Employers Insurance Company – Preferred Select MPN**

puede dirigirse al sitio web de la DWC en [www.dir.ca.gov/dwc](http://www.dir.ca.gov/dwc) y pulsar “medical provider networks” (redes de proveedores médicos) para más información sobre las MPN.

- **Revisión médica independiente:** Si tiene alguna consulta sobre el proceso de revisión médica independiente de la MPN, comuníquese con la Unidad Médica de la División de Indemnización al Trabajador en:

DWC Medical Unit  
P.O. Box 71010  
Oakland, CA 94612  
(510) 286-3700 o (800) 794-6900

**Conserve esta información en caso de sufrir una lesión o enfermedad relacionada con el trabajo.**

## TIME OF HIRE PAMPHLET

This pamphlet, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this pamphlet applies to all industrial injuries that occur on or after January 1, 2013.

### WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from using vibrating tools, losing your hearing because of constant loud noise.

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

### Discrimination is illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

### WHAT ARE THE BENEFITS?

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.
- **Permanent disability benefits:** Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:
  - Your doctor's medical reports
  - Your age
  - Your occupation
- **Supplemental job displacement benefits:** This is a voucher for up to \$6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:
  - You have a permanent disability.
  - Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least \$224 per week. In addition, workers' compensation provides a burial allowance.

### **OTHER BENEFITS**

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site [www.edd.ca.gov](http://www.edd.ca.gov).

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relation's special earnings loss supplement program also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to [www.dwc.ca.gov](http://www.dwc.ca.gov) and looking under "Workers'

Compensation programs and units” for the “Information & Assistance Unit” link or visit the DIR web site at [www.dir.ca.gov](http://www.dir.ca.gov).

**Workers’ compensation fraud is a crime**

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers’ compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to \$150,000 and/or serve up to five years in jail.

**WHAT SHOULD I DO IF I HAVE AN INJURY?**

**Report your injury to your employer**

Tell your supervisor right away no matter how slight the injury may be. Don’t delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

If you cannot report to the employer or don’t hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

**Workers’ compensation insurance company or if employer is self-insured, person responsible for handling the claim is:**

\_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_.

You may be able to find the name of your employer’s workers’ compensation insurer at [www.caworkcompcoverage.com](http://www.caworkcompcoverage.com). If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at [www.dir.ca.gov/DLSE](http://www.dir.ca.gov/DLSE) as all employees must be covered by law.

**Get emergency treatment if needed**

If it’s a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

**Emergency telephone number:** Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

\_\_\_\_\_.

### **Fill out DWC 1 claim form and give it to your employer**

Your employer must give you a [DWC 1 claim form](#) within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case, you may receive up to \$10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

## **MORE ABOUT MEDICAL CARE**

### **What is a Primary Treating Physician (PTP)?**

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

### **What is a Medical Provider Network (MPN)?**

An MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

### **What is Predesignation?**

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the “predesignation of personal physician” form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to the prohibition on a chiropractor continuing as your treating physician after 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers’ Compensation’s Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

#### **WHAT IF THERE IS A PROBLEM?**

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn’t work, get help by trying the following:

#### **Contact the Division of Workers’ Compensation (DWC) Information and Assistance (I&A) Unit**

All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) and under “Workers’ Compensation programs and units”, click on “Information & Assistance Unit.” At this site you will find fact sheets, guides and information to help you.

The nearest I&A Unit is located at:

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_.

### **Consult with an attorney**

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may 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 website at [www.californiaspecialist.org](http://www.californiaspecialist.org). You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

### **Warning**

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

### **Additional rights**

You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

Revised 6/17/14 and effective for dates of injuries on or after 1/1/13

## PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

### NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

**Employee: Complete this section.**

To: \_\_\_\_\_ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
(name of doctor)(M.D., D.O., or medical group)

\_\_\_\_\_  
(street address, city, state, ZIP)

\_\_\_\_\_  
(telephone number)

Employee Name (please print):

Employee's Address:

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: I agree to this Predesignation:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

## **§ 9783.1. DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist.**

### **NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST**

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

**NOTE:** If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

#### **Your Chiropractor or Acupuncturist's Information:**

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**(name of chiropractor or acupuncturist)**

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**(street address, city, state, zip code)**

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**(telephone number)**

Employee Name **(please print):**

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Employee's Address:

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Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_