ILLNESS AND INJURY POLICY AND PROCEDURE

POLICY

The purpose of this General Order is to set forth the procedures to be followed by members (sworn officers) or professional staff in the event of either occupational or non-occupational illness or injury.

PROCEDURE

DUTY TO COMPLETE REPORTS

Any employee who is injured or becomes ill is responsible for seeing that the required report(s) are completed within the time requirements set forth in this order. In the event of an occupational illness or injury, the employee’s immediate supervisor shall complete the report(s) when the employee is unable.

REPORTING ILLNESS OR INJURY

When an employee is injured on-duty, becomes ill or suffers a recurrence of a previous injury or illness and must leave work, he/she shall notify their supervisor and complete a Sheriff’s Office Absentee Report prior to leaving work. The supervisor shall investigate the circumstances of the reported illness or injury and will make appropriate entries on the Absentee form submitted by the employee, and notify the Division/District Commander.

If the illness or injury is the result of a recurrence of a prior occupational illness or injury, the employee shall also notify the Administration Division, Professional Standards Section. If the office is closed, the notification will be made at the beginning of the next business day or as soon as possible.

Whenever an employee, off-duty, becomes ill, is injured or suffers a recurrence of an old on-duty injury or off-duty injury and it is evident that he or she will not be able to report for duty as scheduled, he/she shall notify their unit Commander or their designated representative by telephone.

If the injury is work related the employee, whether on-duty or off-duty, shall also provide information necessary to complete the required Workers’ Compensation forms or seek assistance from their supervisor in completing them if unable to do so. The required Workers’ Compensation Forms are:

- Employee’s Claim for WC Benefits - DWC-1
- Employer’s Report of Occupational Injury or Illness – 5020

The supervisor will provide the employee a dated copy of the DWC-1 form within 24 hours of knowledge/notice of a claim. (Complete line 12 when providing form to employee and retain a copy as proof of date of delivery). The form should be mailed to the employee’s home if he/she is not immediately available.

The supervisor will then complete a Employer’s Report of Occupational Injury or Illness (5020) and a Marin County Accident, Injury & Illness Investigation Report within 24 hours of notice/knowledge for all
occupational illnesses or injuries. The 5020 form is not an admission of liability and should be completed even in the event that no medical treatment is required; medical treatment is declined or just first aid is provided.

All four completed documents shall be forwarded to the Division/District Commander prior to the end of shift. Unit Commanders shall ensure that the Injury and Illness Section, line 35 on Form 5020 contains information that describes the symptoms of the disability and does not identify the cause. Examples of appropriate entries are chest pains (not heart attack), pain and swelling in ankle (not sprained ankle), fever, coughing, upset stomach (not flu).

The Commander will review the Absentee Report form, keep the pink copy for the Division's records, forward the yellow copy to the person responsible for scheduling for that Division and forward the white copy with Workers' Compensation forms to the Administration Division as expeditiously as possible. The Administration Division shall forward the completed Workers’ Compensation forms within five (5) working days from knowledge of an injury or illness to the Workers Comp Liaison, Risk Management Department, Room 421.

- Absentee Report form Original (white) – Personnel File (other then illness or injury) / Medical File (if illness or injury)
- Employee's Claim for Worker Comp Benefits (DWC-1) – copy to Employee’s Medical File, and all other copies to Worker’s Comp Liaison, Risk Management Department
- Employer’s Report of Occupational Injury or Illness (5020) – copy to Employee’s Medical File, and all other copies to Worker’s Comp Liaison, Risk Management Department
- Marin County Accident, Injury & Illness Investigation Report – copy to Administration Division, and original to Risk Management Department

SERVICE CONNECTED DISABILITIES (MEMBERS ONLY)

Service connected disabilities for sworn officers/members such as heart attack, tuberculosis, hernia, pneumonia, cancer, etc. are presumed compensable consequences of employment. These conditions, whether occurring on or off-duty, will be reported as occupational injuries.

MEDICAL TREATMENT FOR ON-DUTY PERSONNEL

The immediate supervisor is responsible for obtaining immediate medical attention for an employee who is injured on-duty. In non-emergency situations the employee shall be directed to an approved medical facility/provider.

For any serious or emergency on-duty injury or illness, personnel will report to the nearest hospital. An employee may be transported by ambulance or other appropriate means of transport at the discretion of the responsible individual on the scene.

The supervisor of the injured/ill member or professional staff is responsible for notifying the commanding officer as soon as possible. If the injury or illness requires inpatient hospitalization, the supervisor shall also notify the Sheriff, Undersheriff and Bureau Commander as soon as possible. The Administration Division Commander shall notify the County Safety Officer and Workers Comp Liaison in Risk Management of serious injury/illness, hospitalization or death the next business day via voice or email.

INJURIES RECEIVED DUE TO ASSAULTS

Whenever an on-duty member receives injuries because of an assault by a citizen, such as 148 or 243 PC cases, the injured officer must immediately request that his/her supervisor respond to the scene. When an officer is so seriously injured that he cannot do so, the notification shall be made by any other officer at the scene.
The notified supervisor shall insure that photographs are taken of the injured officer. They shall be taken as soon as practicable after the officer’s medical condition has been stabilized. The photographs with supplemental crime report will be forwarded to the Records Section with a request for copies to the Investigations Division for follow-up. The supervisor will forward a memo to the Sheriff, through the chain of command, describing the nature of the assault and injuries.

REPORTING WHEREABOUTS WHILE OFF-DUTY

When an employee who is off work for either an occupational or non-occupational illness or injury, he or she shall not absent themselves from the County of their residence for more than twenty-four (24) hours without advising their Division/District Commander of their destination and probable time of return.

If out of the area for forty-eight (48) or more hours he/she must provide a contact phone number where they can be reached. Upon returning home after an absence from the County of residence for more than forty-eight (48) hours the member or professional staff shall telephone the Unit Commander or his designated representative and advise of his/her return.

In all situations, it is the responsibility of the employee to be sure that the party to whom it was directed receives any message left.

When assigned to an organizational unit that does not operate on a twenty-four hour basis and the required notifications are made during non-operating hours, the member or professional staff shall telephone the Patrol Division Watch Commander or his designated representative and provide the required information.

When an employee is assigned to the Administration Division in an extended illness or injury status he/she shall telephone the Administrative Lieutenant, or Professional Standards Sergeant if the Lieutenant is unavailable, once each week unless otherwise directed. The purpose of the call shall be to provide a progress report, and obtain any messages that may have been left for the member or professional staff.

If hospitalized for more than 24 hours, the employee or an alternative family member (or designated representative) shall provide the name of the hospital and the reason for the hospitalization to his/her current organizational unit.

OUTSIDE EMPLOYMENT WHILE OFF-DUTY DUE TO ILLNESS OR INJURY

Whenever an employee is off work due to injury or illness or is on a modified duty assignment, he/she shall not work at or be present at any outside employment or job site in any work related capacity. Any authorization issued by the County or department for outside employment will be considered suspended until the member or professional staff has been cleared by the treating physician to return to their usual and customary, full time status.

TRANSFER OF PERSONNEL TO ADMINISTRATION DIVISION

An employee absent from duty for thirty (30) consecutive calendar days will be temporarily transferred to the Administration Division in an extended illness or injury status. They will remain on the roll of their assigned Division. Transfer may take place earlier if modified duty is provided.

When an employee has reached his/her thirtieth (30th) day of absence, the Administration Division shall submit a report to the Sheriff containing the following information:

- Number of years the person has been employed.
- Work Status
- Length of Disability
• Estimated return to work
• Amount of ill and vacation time remaining

RETURNING TO WORK IN A TEMPORARY MODIFIED DUTY CAPACITY

All modified duty assignments will be handled in accordance with the Modified Duty Policy, General Order GO-02-10.

• When an injured or ill employee is released by their treating physician to temporary modified duty the employee’s Division Commander will notify the Administration Division.

• No member or professional staff shall be permitted to return to a modified duty assignment without express written approval from the Administration Division.

RETURNING TO REGULAR DUTY ASSIGNMENT

An employee who has been off three or more work days recovering from illness or injury shall immediately telephone his Unit Commander or his designated representative and state his/her availability and intention to return to duty.

An employee returning to full duty following either an occupational or non-occupational disability must first obtain a work status report or statement from their treating physician indicating that he/she is fully capable of performing all the duties of his/her usual and customary position without restrictions when:

• Returning after a period of disability due to a new or re-occurring occupational injury
• Returning from modified duty assignment
• Has been off duty greater than three (3) work days or unless otherwise directed by supervisor or Unit Commander
• Has been hospitalized overnight
• Returning from an illness or injury which was either recurring or serious in nature

The employee shall report to his/her unit of assignment with the appropriate release to full duty. Should any Unit Commander have any doubt as to the ability of an employee to return to his usual & customary assignment following illness or injury, he or she shall refer them to the Administration Division for a fitness for duty examination.

Unit Commanders shall not permit an employee to return to full duty without first receiving documentation of clearance from the designated treating physician or fitness for duty physician.

APPENDIXES

A – Absentee Report form
B – Employee’s Claim for Worker Comp Benefits (DWC-1)
C – Employer’s Report of Occupational Injury or Illness (5020)
D – Marin County Accident, Injury & Illness Investigation Report Form

RELATED STANDARDS:

Modified Duty Policy [General Order GO-02-10]

Civil Code 56.20-56.245
Government Code §12940.1
Health & Safety Code
Labor Code §132a, 230.3, 3212, 3300-3371, 3600, 3600.2, 3600.6, 4050-4056, 4062, 4351-4354, 4644,
4850, 6409.2, 6412
California Code of Regulations
County of Marin County Code
Marin County Administrative Regulations #3 & 22

AFFECTED DIVISIONS:

All

DATE OF REVISIONS:

1989
10/4/95
9/96
11/7/00
1/30/03

By Order of

ROBERT T. DOYLE
SHERIFF
## APPENDIX A

### MARIN COUNTY SHERIFF’S OFFICE

### ABSENTEE REPORT

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE REPORTED</th>
<th>TIME REPORTED</th>
<th>AM PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUTY ASSIGNMENT</td>
<td>ASSIGNED DAYS OFF</td>
<td>REPORTED RECEIVED BY</td>
<td></td>
</tr>
<tr>
<td>PROBABLE DATES ABSENT</td>
<td>PROBABLE RETURN DATE</td>
<td>APPROVED BY</td>
<td></td>
</tr>
</tbody>
</table>

### REASON FOR ABSENCE

- Sick
- Injury
- Illness in Family
- Military Duty
- Jury Duty
- Industrial Accident
- Death of Relative
- Transportation Problem
- Tardiness
- Other (explain below)

### REPORTED BY

- Wife
- Other Relative
- Self
- Friend
- Doctor
- Phone
- Letter
- Other Employee
- In Person
- Other (explain below)

### WHERE WILL EMPLOYEE BE DURING ABSENCE

### COMMENTS

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**Distribution**

- Original (white) – Personnel File (other then illness or injury) / Medical File (if illness or injury)
- Second copy (yellow) – Scheduling
- Third copy (pink) – Division file
APPENDIX - B

EOS GROUP
Employer and Occupational Services
State of California
Department of Industrial Relations
DIVISION OF WORKERS’ COMPENSATION

EMPLOYEES’ CLAIM FOR WORKERS’ COMPENSATION BENEFITS

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

Complete the “Employee” section and give the form to your employer. The copy marked “Employee’s Temporary Receipt” until you receive the dated copy from your employer. You may contact the State’s Office of Benefit Assistance and Enforcement at 1-800-736-7491 if you need help in filling out this form or in obtaining your benefits. An explanation of workers’ compensation benefits is included on the reverse of this form.

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

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<table>
<thead>
<tr>
<th>Employee: Empleado:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name, Nombre, ________________________________ Today’s Date, Fecha de hoy ____________________</td>
</tr>
<tr>
<td>2. Home address, Dirección Residencial, ________________________________</td>
</tr>
<tr>
<td>3. City, Ciudad ________________________________ State, Estado, ________________________________ Zip, Código Postal ________________________________</td>
</tr>
<tr>
<td>4. Date of Injury, Fecha de la lesión (accidente) ________________________________ Time of injury, Hora en que ocurrió, a.m., p.m. ________________________________</td>
</tr>
<tr>
<td>5. Address and description of where injury happened, Dirección/dónde ocurrió el accidente, ________________________________</td>
</tr>
<tr>
<td>6. Describe injury and part of body affected, Describa la lesión y parte del cuerpo afectada, ________________________________</td>
</tr>
<tr>
<td>7. Social Security Number, Número de Seguro Social del Empleado, ________________________________</td>
</tr>
<tr>
<td>8. Signature of employee, Firma del empleado ________________________________</td>
</tr>
</tbody>
</table>

---

Empelador: 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

Original (Employee’s Copy)
DWC Form 1 Rev. 1/94 60.5004.1715.53130 (09/97)
ES20100

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SIGNED THE EMPLOYER FOR THE SIGNIFICANT ADMISSION OF RESPONSIBILITY

Original (Copy of the Employer)
DWC Form 1 Rev. 1/94
### APPENDIX – C

**State of California**

**EMPLOYER’S REPORT OF OCCIDENTIAL INJURY OR ILLNESS**

- **No. CA**
  - P.O. Box 9550
  - Walnut Creek, CA 94598
  - (510) 930-3680
- **So. CA**
  - P.O. Box 70447
  - Oakland, CA 94612
  - (800) 977-9846
- **OSHA Case No.**
  - [Select one]
  - Fatality

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

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

#### EMPLOYEE

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Firm Name</td>
<td>[Company Name]</td>
</tr>
<tr>
<td>2. Mailing Address</td>
<td>[Address]</td>
</tr>
<tr>
<td>3. Location</td>
<td>[Location]</td>
</tr>
<tr>
<td>4. Nature of Business</td>
<td>[Business Type]</td>
</tr>
<tr>
<td>5. Type of Employer</td>
<td>[Private, State, City, County, School District]</td>
</tr>
<tr>
<td>6. Social Security Number</td>
<td>[Number]</td>
</tr>
<tr>
<td>7. Employee Name</td>
<td>[Name]</td>
</tr>
<tr>
<td>8. Home Address</td>
<td>[Address]</td>
</tr>
<tr>
<td>9. Sex</td>
<td>[Male, Female]</td>
</tr>
<tr>
<td>10. Occupation</td>
<td>[Occupation]</td>
</tr>
<tr>
<td>11. Date of Injury or Illness</td>
<td>[Date]</td>
</tr>
<tr>
<td>12. Time Injured/Illness Occurred</td>
<td>[Time]</td>
</tr>
<tr>
<td>13. Time Employee Began Work</td>
<td>[Time]</td>
</tr>
<tr>
<td>14. If Employee Worked During the Week of Injury</td>
<td>[Yes, No]</td>
</tr>
<tr>
<td>15. Date Employee Returned to Work</td>
<td>[Date]</td>
</tr>
<tr>
<td>16. Date Employee Began Work</td>
<td>[Date]</td>
</tr>
<tr>
<td>17. Date Employee Completed Work</td>
<td>[Date]</td>
</tr>
<tr>
<td>18. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>19. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>20. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>21. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>22. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>23. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>24. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>25. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>26. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>27. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>28. Days Worked Since Injured</td>
<td>[Number]</td>
</tr>
<tr>
<td>29. Days Worked During the Week of Injury</td>
<td>[Number]</td>
</tr>
<tr>
<td>30. Location Where Event or Exposure Occurred</td>
<td>[Location]</td>
</tr>
<tr>
<td>31. Department Where Event or Exposure Occurred</td>
<td>[Department]</td>
</tr>
<tr>
<td>32. Event</td>
<td>[Event]</td>
</tr>
<tr>
<td>33. Exposure</td>
<td>[Exposure]</td>
</tr>
<tr>
<td>34. Specific Activity the Employee Was Performing When Event or Exposure Occurred</td>
<td>[Activity]</td>
</tr>
<tr>
<td>36. Name and Address of Physician</td>
<td>[Name and Address]</td>
</tr>
<tr>
<td>37. Date of Injury or Illness</td>
<td>[Date]</td>
</tr>
</tbody>
</table>

**Signature**

[Signature]

[Title]

[Date]

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**FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY**

**ASSOCIATED FILE**