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

NAME	DATE REPORTED	TIME REPORTED	AM PM
DUTY ASSIGNMENT	ASSIGNED DAYS OFF	RECEIVED BY	
PROBABLE DATES ABSENT	PROBABLE RETURN DATE	APPROVED BY	

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
- Other (explain below)

MESSAGE RECEIVED BY

- Phone
- Letter
- Other Employee
- In Person
- Other (explain below)

REASON FOR ABSENCE

WHERE WILL EMPLOYEE BE DURING ABSENCE

COMMENTS

Distribution
White – Personnel File (if non-illness) / Medical File (if illness or injury)
Yellow - Scheduling
Pink – Division File

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

EOS | GROUP

Employer and Occupational Services

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

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

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

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

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.

Northern California
P.O. Box 9350 • Walnut Creek, CA 94598 • (510) 930-9883
P.O. Box 70447 • Oakland, CA 94612 • (510) 286-8799
Southern California
P.O. Box 19754 • Irvine, CA 92623 • (800) 977-0286

Estado de California
Departmento de Relaciones Industriales
DIVISION DE COMPENSACIÓN TRABAJADOR

RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de las Leyes Pertinentes llamando al **1-800-736-7401.** Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que con conocimiento 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 ("felonía").

Employee: *Empleado:*

1. Name. *Nombre.* _____ Todays's Date. *Fecha de Hoy.* _____
2. Home address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of injury. *Hora en que ocurrió.* _____ *a.m.* _____ *p.m.*
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Numero de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and give the employee a copy immediately as a receipt.
***Empleador**—complete esta sección y déle inmediatamente una copia al empleado como recibo.*

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

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañia de seguros y empleado, dependiente o representante que haya presentado esta petición dentro del plazo de **un dia hábil** desde el momento de haber sido recibida la forma completa del empleado..

EL FIRMA ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Original (Employer's Copy)
DWC Form 1 (Rev. 1/94) 60.5004.1715.83130 (8/97)
E5220100

ORIGINAL (Copia del Empleador)
DWC Form 1 (Rev. 1/94)

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

EOS | GROUP
Employer and Occupational Services

No. CA
☐ P.O. Box 9350
Walnut Creek, CA 94598
(510) 930-9883

☐ P.O. Box 70447
Oakland, CA 94612
(800) 977-8846

So. CA
☐ P.O. Box 19754
Irvine, CA 92623-9754
(949) 788-8540

OSHA Case No.

☐ 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 every occupational injury or illness which results in lost time beyond the date of the incident ***OR*** 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 **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or fatality must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
4. POLICY NUMBER
DO NOT USE THIS COLUMN

2. MAILING ADDRESS (Number and Street, City, ZIP)
5. PHONE NUMBER
Case No.

3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
6. LOCATION CODE
Ownership

4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
Industry

6. TYPE OF EMPLOYER
☐ Private ☐ State ☐ City ☐ County ☐ School District ☐ Other government – specify: _____
Occupation

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm/dd/yy)
Sex

10. HOME ADDRESS (Number and Street, City, Zip)
10A. PHONE NUMBER
Age

11. SEX ☐ Male ☐ Female
12. OCCUPATION (Regular job title – NO initials, abbreviations or numbers)
13. DATE OF HIRE (mm/dd/yy)
Daily hours

14. EMPLOYEE USUALLY WORKS hours _____ per day days _____ per week total _____ weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury) regular ____ full-time ____ part-time ____ temporary ____ seasonal
14B. Under what class code of policy were wages assigned?
Days per week

15. GROSS WAGES/SALARY $_____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ Yes, $_____ per _____ ☐ No
Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
Weekly wage

21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
22. DATE LAST WORKED (mm/dd/yy)
23. DATE RETURNED TO WORK (mm/dd/yy)
24. IF STILL OFF WORK CHECK THIS BOX ☐
County

25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
26. SALARY BEING CONTINUED? ☐ Yes ☐ No
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
28. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)
Nature of Injury

29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of right elbow, lead poisoning.
Part of body

30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
Source

31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT ☐ Yes ☐ No
Event

33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source

34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading bricks onto truck.
Extent of Injury

35. 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

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER

37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

COMPLETED BY (type or print)	SIGNATURE	TITLE	DATE

E5220098 FORM 5020 (REV. 8) 1992

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

ASSOCIATED FILE