I. INTRODUCTION

A. Workers’ Compensation is a benefit paid to an Employee when s/he has sustained an injury or illness arising out of and in the course of employment: All SFUSD Employees are eligible to receive Workers’ Compensation benefits:

B. California law requires an employer to report within five days, every industrial injury or occupational illness which results in lost time beyond the day of injury or requires medical treatment other than first aid. Likewise, Board of Education Policy P3410 mandates that “Employees are required to report any work related injuries/or illnesses to their supervisor as soon as practicable.”

C. Volunteers, who are unsalaried persons, performing services at SFUSD sites are not eligible to receive Workers’ Compensation benefits.

D. SFUSD is self-insured for most workers compensation costs. The City & County of San Francisco’s Department of Human Resources - Workers Compensation Division administers, adjusts and investigates claims resulting from employment related illnesses and injuries. The District has purchased excess workers compensation insurance from an independent insurance company for claims in excess of $250,000 per occurrence. Accordingly, the District’s insurance company also may adjust, investigate and settle workers compensation claims.

II. REPORTING INJURY OR ILLNESS

One of the key elements in a successful Worker’s Compensation Program is the prompt reporting of injuries/illnesses. This permits timely processing of claims, correct payroll payments and ultimately lower costs to the District. All Employees are required to adhere to these procedures.

A. The Employee’s Claim for Workers’ Compensation Benefits, DWC Form 1 (See Attachment 1) must be given to the injured Employee within 24 hours of notice of the injury.
B. As soon as possible after notice of the injury/illness, the Employee’s Supervisor should prepare the Employer’s Report of Occupational Injury or Illness, Form 5020. (See Attachment 2)

C. Supervisors are responsible for reporting all work-related injuries or illnesses. “Supervisors” are defined as either the School Principal, Child Development Program Site Manager, or the Department Heads for centralized services-

D. Both forms (DWC Form 1 and Form 5020) must be filled out completely and forwarded to:

SFUSD, Benefits & Deductions Office
135 Van Ness Avenue, Room 123
San Francisco, CA 94102
Tel. 522-6744.

Any questions should also be directed to the SFUSD Benefits & Deductions Office.

E. Should the Supervisor want to provide additional information or comments regarding the injury/illness, a memo may be attached to the Employer’s Report. The Employer’s Report is also to be used to report an incident, even though there may be no loss of work time or medical treatment sought.

F. When an Employee requires medical treatment, the Employee must report to the SFUSD designated treatment facility indicated below unless an Employee has made a prior designation to the contrary:

UCSF/Mount Zion Hospital Occupational Medicine Clinic
1515 Scott Street (between Geary and Post)
San Francisco, CA
Tel. 8857770

Clinic hours are between 8:00 A.M. and 5:00 P.M., Monday through Friday. No appointment is necessary. For after hours or weekend injuries, all Employees should report to the Mt. Zion Emergency Department which is located on Sutter Street, between Divisadero and Scott.

SAN FRANCISCO UNIFIED SCHOOL DISTRICT
G. After an Employee is examined, she will be provided with an Attending Physician’s Report which indicates Employee’s release to full duty or disability status. Employee should return this form to her/his Supervisor immediately.

H. Should an Employee decline medical treatment, this should be indicated on Form 5020. The Employee must also sign and date the Non-Acceptance of Medical Treatment form. (See Attachment 3).

I. In the event of death of the Employee, the Employee’s Supervisor is required to immediately notify the designated next of kin the department head, the Manager of the Benefits & Deductions Office and the Employee’s Union representative (if any). The Department head i.e., Associate Superintendent, Assistant Superintendent or Director is responsible for notifying the Superintendent, Deputy Superintendent Chief Financial Officer, Associate Superintendent for Human Resources and the Director of Public Affairs.

III. PAYMENTS TO EMPLOYEES DURING INDUSTRIAL INJURY/ILLNESS

A. Certificated Employees.
Payments to Certificated Employees will be made in accordance with Education Code Section 44984 and the terms and conditions of their applicable collective bargaining agreements (if any).

B. Classified Employees.
Payments to these Employees will be made in accordance with Education Code Section 45 192 and the terms and conditions of their collective bargaining agreements (if any).

IV. SUBSTITUTE/TEMPORARY/AS-NEEDED EMPLOYEE BENEFITS DURING工業傷病 BENEFITS DURING INDUSTRIAL INJURY/ILLNESS

Substitutes, temporary, and as-needed Employees may be eligible for direct payments of Workers’ Compensation benefits, based on average weekly wages for the year prior to the claimed injury.
V. **RETURN TO WORK**

It is an SFUSD goal to return all Employees to work as soon as medically reasonable. An Employee on industrial leave may return to work only when his/her Supervisor has been provided with a written medical release to return to work from her/his attending medical provider. When an Employee returns to work after an industrial leave the Employee’s Supervisor must notify the Benefits & Deductions Office by providing a copy of the physician’s medical release returning the Employee to work and submitting it with the Return to Work Report (Attachment 4).

VI. **REOCCURRENCE OF INJURY**

If an Employee returns to work and subsequently misses additional work time due to the same injury/illness, the Employee must notify his supervisor that this is a continuation of the same injury and the Supervisor must notify the Benefits & Deductions Office immediately. If the Employee re-injures himself, it is imperative to notify the Benefits & Deductions Office to facilitate the determination of whether there is a new injury or an aggravation of an old injury.

VII. **MODIFIED DUTY**

At the discretion of the Supervisor, temporary modified duty may be available. Temporary modified duty is the temporary assignment of an Employee to either perform a portion of her/his regular duties which may include performing the duties of the position less than full-time or to perform the duties of another position for which the Employee is medically able.

A. Written release to modified duty must be provided by the attending physician before an assignment can be made. The release must list the Employee’s work restrictions and the anticipated duration of these work restrictions. The release should be provided to the Employee’s Supervisor the same day as the release was provided to the employee but no later than the next business day.

B. Modified duty assignments may only be made with the approval of the Department Head and must be indicated on the Temporary Limited/Modified Duty Plan form (see page 11 attached). In some instances, it may be necessary to consult with the Benefits & Deductions Office prior to making a modified duty assignment. At the discretion of the Supervisor, an Employee may be assigned to a different division and/or shift.
C. Assignments will be made on a case-by-case basis and take into consideration the ability to accommodate an Employee’s work restrictions, the Employee’s ability to perform the tasks associated with the assignment, and the operational needs of the particular site.

D. When a modified duty assignment is approved by the Supervisor, the Employee will be notified in writing, including the dates of the assignment, location, work schedule and brief statement of duties.

E. Modified duty will be monitored at bi-weekly intervals by the Supervisor and the attending physician to determine whether the modification should be continued. Modified duty will be limited to a maximum of 3 months for any one injury or illness.

F. An Employee will be notified in writing by the Supervisor when a modified duty assignment cannot be continued or has terminated.

G. Employees who refuse modified duty after a physician has released him/her to perform such duties, will no longer be eligible to receive Workers Compensation benefits. If the Employee remains off work, he/she must utilize sick or vacation time during absence from work. Said Employee may then be subject to disciplinary action.

VIII. REHABILITATION

SFUSD will provide Rehabilitation Benefits to those Employees determined to be eligible in accordance with Labor Code Section 6200, et seq.

IX. EMPLOYEE STATUS AFTER SALARY DISCONTINUANCE

A. Certificated Employees who have exhausted all paid leave including sick leave and vacation, who fail to either return to work or request an unpaid leave, will be deemed to have abandoned their position. The District may then initiate appropriate disciplinary action.

B. Classified Employees covered by collective bargaining agreements who have exhausted all paid leave, including sick leave and vacation, will be placed on a re-employment list for 39 months.
C. Classified Employees not covered by collective bargaining agreements who have exhausted all paid leave including sick leave and vacation, who fail to either return to work or request an unpaid leave, will be deemed to have abandoned their position and may be terminated.

D. Requests for unpaid leave of absences following salary discontinuance should be addressed to:

   Associate Superintendent of Human Resources
   135 Van Ness Avenue, Room 116
   San Francisco, CA 94102

   The Associate Superintendent of Human Resources may authorize an unpaid leave of absence of up to 2 years at the District’s discretion.

E. An Employee on approved unpaid leave or a classified employee on the 39 month re-employment list may continue coverage under SFUSD insurance programs by making the necessary allowable premium payments in a timely manner directly to the insurance carrier.

X. MEDICAL APPOINTMENTS

An Employee may be absent without loss of sick or vacation pay for the time necessary to secure any medical examination required by SFUSD. An Employee who sustains a work-related injury will not be debited sick or vacation pay for the day of the injury, provided s/he reports for medical treatment on the day of injury. Follow-up appointments with Employee’s attending physician for work-related injuries shall be charged to sick or vacation time.
XI. INQUIRIES

For assistance in completing Forms or questions regarding Workers’ Compensation procedures, please contact:

SFUSD Benefits & Deductions Office
135 Van Ness Avenue, Room 123
San Francisco, CA 94102
Tel. 522-6744.

HISTORY/AUTHORIZATION:

July 1997

Waldemar Rojas
Superintendent of Schools

William F. Coleman, III
Chief Financial Officer

SAN FRANCISCO UNIFIED SCHOOL DISTRICT
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.

Employee—complete this section and immediately give the employer a copy as a receipt.

Employer—complete this section and immediately give the employee a copy as a receipt.

Employee's Name: [Name]

Home Address: [Address]

City: [City]

State: [State]

Zip: [Zip]

Social Security Number: [Number]

Signature of Employee: [Signature]

The above information is true to the best of my knowledge and belief.

Employee Signature: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

Employer's Name: [Name]

Home Address: [Address]

City: [City]

State: [State]

Zip: [Zip]

Social Security Number: [Number]

Signature of Employer: [Signature]

The above information is true to the best of my knowledge and belief.

Employer Signature: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

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

Signature of Employee: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

Signature of Employer: [Signature]

The above information is true to the best of my knowledge and belief.

Employer Signature: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

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

Signature of Employee: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

Signature of Employer: [Signature]

The above information is true to the best of my knowledge and belief.

Employer Signature: [Signature]

Date: [Date]

City: [City]

State: [State]

Zip: [Zip]

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.
IMPORTANT - Item 36 - All injured employees now report to UCSF/Mt. Zion Occupational Medicine Clinic 1315 Scott St., San Francisco, CA 94113 Tel: 385-7770

City & County of San Francisco

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 injury or illness. Employer must file within five days of knowledge of an amended report indicating death. In addition, every serious injury/fatality, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

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Government

1. EMPLOYER NAME:

2. WORK ADDRESS (Number and Street, City, CA, ZIP):

3. TELEPHONE NUMBER:

4. D.O.B.:

5. SOCIAL SECURITY NUMBER:

6. EMPLOYER NAME:

7. EMPLOYER ADDRESS (Number and Street, City, CA, ZIP):

8. TELEPHONE NUMBER:

9. D.O.B.:

10. SOCIAL SECURITY NUMBER:

11. EMPLOYER NAME:

12. WORK ADDRESS (Number and Street, City, CA, ZIP):

13. TELEPHONE NUMBER:

14. D.O.B.:

15. SOCIAL SECURITY NUMBER:

16. EMPLOYER NAME:

17. WORK ADDRESS (Number and Street, City, CA, ZIP):

18. TELEPHONE NUMBER:

19. D.O.B.:

20. SOCIAL SECURITY NUMBER:

21. EMPLOYER NAME:

22. WORK ADDRESS (Number and Street, City, CA, ZIP):

23. TELEPHONE NUMBER:

24. D.O.B.:

25. SOCIAL SECURITY NUMBER:

26. EMPLOYER NAME:

27. WORK ADDRESS (Number and Street, City, CA, ZIP):

28. TELEPHONE NUMBER:

29. D.O.B.:

30. SOCIAL SECURITY NUMBER:

31. EMPLOYER NAME:

32. WORK ADDRESS (Number and Street, City, CA, ZIP):

33. TELEPHONE NUMBER:

34. D.O.B.:

35. SOCIAL SECURITY NUMBER:

36. EMPLOYER NAME:

37. WORK ADDRESS (Number and Street, City, CA, ZIP):

38. TELEPHONE NUMBER:

39. D.O.B.:

40. SOCIAL SECURITY NUMBER:

41. EMPLOYER NAME:

42. WORK ADDRESS (Number and Street, City, CA, ZIP):

43. TELEPHONE NUMBER:

44. D.O.B.:

45. SOCIAL SECURITY NUMBER:

46. EMPLOYER NAME:

47. WORK ADDRESS (Number and Street, City, CA, ZIP):

48. TELEPHONE NUMBER:

49. D.O.B.:

50. SOCIAL SECURITY NUMBER:

51. EMPLOYER NAME:

52. WORK ADDRESS (Number and Street, City, CA, ZIP):

53. TELEPHONE NUMBER:

54. D.O.B.:

55. SOCIAL SECURITY NUMBER:

56. EMPLOYER NAME:

57. WORK ADDRESS (Number and Street, City, CA, ZIP):

58. TELEPHONE NUMBER:

59. D.O.B.:

60. SOCIAL SECURITY NUMBER:

61. EMPLOYER NAME:

62. WORK ADDRESS (Number and Street, City, CA, ZIP):

63. TELEPHONE NUMBER:

64. D.O.B.:

65. SOCIAL SECURITY NUMBER:

66. EMPLOYER NAME:

67. WORK ADDRESS (Number and Street, City, CA, ZIP):

68. TELEPHONE NUMBER:

69. D.O.B.:

70. SOCIAL SECURITY NUMBER:

71. EMPLOYER NAME:
RETURN TO WORK REPORT

Instructions to Supervisor:

Complete this form, attach the physician’s release-to-return-to-work-form, and send it to:

SFUSD Benefits & Deductions Office,
135 Van Ness Avenue, Room 123
San Francisco, CA 94102

Employee’s Name ____________________________

Date Injured ______________ Initial Date of Absence ______________

Date Returned to Work _______________________

________________ Returned to Full-Time Work

________________ Returned to Part-Time Work       No. of Hours _______

________________

Supervisor’s Signature

Date

ATTACHMENT 3
I, ____________________________, hereby decline all medical treatment for the

alleged industrial injury/illness sustained by me on ____________________________.

______________________________

Location of Accident

______________________________    ____________________________

Employee’s Signature                  Today’s Date

ATTACHMENT 4
Temporary Limited/Modified Duty Plan

Employee: ____________________________  SSN#: ____________________________

Home Add: ____________________________  Home ____________________________

Phone: ____________________________  Phone: ____________________________

Personal/Work Related: P W  Date of Injury: ____________________________

Position: ____________________________  Location: ____________________________

Supervisor: ____________________________  Phone/Ext.: ____________________________

Temporary Restrictions (from attached physician’s statement):

Description of Temporary Duty Assignment:

Beginning Date: ____________________________  (Ending date or next Doctor Appt.)

Supervised By: ____________________________

CHECK ONE AND SIGN BELOW:

[ ] I have read the information above and accept the assignment/plan offered.

[ ] I have read the information above and decline the offer. I understand that I may use my sick leave benefits until I return to duty or accept a temporary Limited/Modified Duty offer.

Employee Signature ____________________________  Date: ____________________________

Supervisor ____________________________  Date: ____________________________

cc: Benefits and Deductions Office
    Tel. (415)522-6744
    Fax. (415)241-6375

ATTACHMENT 5