CITY OF SACRAMENTO

PERSONNEL POLICY INSTRUCTIONS

TOPIC: POLICY RELATING TO CITY EMPLOYEES PROCEDURES TO BE FOLLOWED FOR THE TREATMENT OF INJURIES OR ILLNESSES INCURRED IN THE COURSE OF EMPLOYMENT.

Effective Date: OCT 1 1984

Supersedes: New

TO: DEPARTMENT HEADS/DIVISION CHIEFS

Section No: IV-84-6

APPROVED: Donna L. Giles
Director of Personnel

APPROVED: Walter J. Slipe
City Manager

SUMMARY OF CONTENTS

POLICY AND PROCEDURE

1. Purpose and Scope

   1.1 To establish the policy, procedures and guidelines for securing treatment of work related injuries or illnesses. It is the intent of this policy and procedure to comply fully with the City's Policy for Safety, Resolution No. 630, adopted by the Sacramento City Council on March 11, 1971, and further, to comply fully with Section 6409.1 of the State of California Labor Code.

2. Definitions - As used in this policy and procedure, the following terms are defined:

   2.1 Supervisor's Investigation Report - RLK Form 1001 (Short).

   2.2 First Report of Injury (Police Department Only) - equal to an RLK Form 1001.

   2.3 Report of Industrial Injury - Form DPM-400.

   2.4 Minor Injury - Scratches, bruises, first degree burns, etc., that do not require treatment by a physician.

   2.5 Significant or Major Injury - requires treatment by a physician.

   2.6 Severe Injury - involving arterial bleeding, breath stoppage, dismemberment, etc., requiring emergency transportation to nearest medical facility.

   2.7 Personal Physician - a licensed medical doctor who has previously directed the treatment of and who retains the employee's medical records and history, within a reasonable geographic area to the City of Sacramento.

3. Policy

   3.1 It is the policy of the City that employees shall be required to report all injuries or illnesses that occur in the course of performance of duties to their supervisor regardless of how slight the injury may appear.

   3.2 It is the responsibility of the supervisor to conduct an investigation of the conditions and events of the workplace at the time of an accident to identify all contributing factors of the injury accident using the appropriate report of industrial injury form.

3.3 It is the responsibility of department supervisors to ensure that all employee reports of injury are submitted in writing to department management for review to identify and correct industrial hazards and safety procedural problems.

3.4 In case of serious injury that (1) results in death from any source, or (2) requires admission to a hospital, the supervisor shall immediately telephone the City Safety Office at 449-5278. Should such serious injury or death occur between the hours of 5:00 p.m. and 8:00 a.m., weekends or holidays, the Police Department shall be called at 449-5471 and request to speak to the shift supervisor.

4. Procedures to be Followed for Treatment of Injuries/Illnesses Incurred in the Course of Employment

4.1 If an employee is injured in the course of performance of duties, he/she must immediately report the incident to his/her supervisor, regardless of how slight the injury may appear.

4.2 If the injury is minor, the supervisor will record the injury on RLK Form 1001 (Police Department will use "First Report of Injury" form) and forward the form through the department and then to the Safety Coordinator.

4.3 If the injury is major and requires the attention of a physician the DPM-400 shall be filled out with all known essential information to assist the physician in treating the injured employee. The information shall include a complete description of the incident.

4.4 With the white copy of the DPM-400, the injured employee will report to one of the following physicians' facilities:

Patrick J. Clancy, M.D.
400 "O" Street, Suite 203
Sacramento, CA 95814
Phone (916) 444-2717
Hours: Monday - Thursday 9:00 a.m. to 12:00 Noon
1:00 p.m. to 5:00 p.m.
Friday 9:00 a.m. to 12:00 Noon

David E. Root, M. D.
One Scripps Drive, Room 205
Sacramento, CA 95825
Phone (916) 924-9263
Hours: Monday - Thursday 9:00 a.m. to 12:00 Noon
2:00 p.m. to 5:00 p.m.
Friday 9:00 a.m. to 12:00 Noon

Medical Clinic of Sacramento
2615 "I" Street
Sacramento, CA 95816
Phone (916) 441-3411 ext. 244
Hours: Monday - Friday 8:30 a.m. to 9:00 p.m.
Saturday - Sunday 10:00 a.m. to 4:00 p.m.

4.5 If the injury or illness should occur between the hours of 5:00 p.m. and 9:00 p.m., Monday through Friday, or between 10:00 a.m. and 4:00 p.m. on Saturday and Sunday, the Medical Clinic of Sacramento shall be utilized. Should the injury or illness occur at any time not listed above, the Medical Clinic of Sacramento's twenty-four (24) hour number (441-3411) shall be called for directions in securing treatment. The on-call physician will make an appropriate referral.

4.6 If the injury is severe, call the 911 Emergency Number and request emergency medical aid and transportation to the nearest emergency medical facility.

4.7 If an employee has notified his/her employer in writing prior to the date of injury, that he/she has a "personal physician" located within a reasonable geographic area, the employee has a right to be treated by that physician from the date of injury. Personal physician is defined as a doctor of medicine or osteopathy, who prior to the injury has directed the medical treatment of the employee and who retains the employee's medical records and medical history. Personal physician includes a corporation, partnership or association of such doctors.

In case of severe injury accidents, the nearest emergency medical treatment facility shall be utilized.

4.8 Employees are not permitted to secure the services of any other physician for treatment of a job incurred injury without the specific authorization of the physicians listed in 4.4 and 4.7 of this policy or the Workers' Compensation Claims Manager.

After 30 days from the date the injury is reported, the employee may be treated by a physician of his/her own choice within a reasonable geographic area (Labor Code Section 4600). It is important that before any change of treating physicians is made that the Workers' Compensation Division be notified.

5. Attachments

5.1 Supervisor's Investigation Report - RLK Form 1001 (Short)

5.2 First Report of Injury (Police Department Only)

5.3 Report of Industrial Injury - Form DPM-400

ATTACHMENT 5.1 (SUPERVISOR'S INVESTIGATION REPORT - RLK Form 1001 - Short)

SUPERVISOR'S INVESTIGATION REPORT

RLK FORM 1001 (Short) 3/73

INSTRUCTIONS:
SUPERVISOR SHOULD COMPLETE **STEP I** WITHIN 24 HRS. —THEN FORWARD TO YOUR OWN COMPANY'S SAFETY PERSONNEL, OR INSURANCE DEPARTMENT.

STEP I

COMPANY: LOCATION:

ADDRESS:

EMPLOYEE: BADGE: AGE:

JOB TITLE:

DATE OF INCIDENT: TIME OF INCIDENT:

DATE REPORTED: TIME REPORTED:

WITNESSES:

NATURE OF INCIDENT/COMPLAINT (describe):

ORIGIN (Circle One) WORK AREA MACH/ EQUIPT. MATERIAL HANDLING HAND TOOL BURN- HEAT, CHEMICAL ELECTRICAL VEHICLE

OTHER (explain):

UNSAFE ACT ☐
UNSAFE CONDITION ☐

EXPLAIN:

HAS PROBLEM BEEN CORRECTED? YES ☐ NO ☐

HOW? (explain):

SUPERVISOR:

STEP II

FORWARD A COPY OF THIS REPORT TO COMPANY SAFETY, PERSONNEL, OR INSURANCE DEPT.

CLASSIFICATION (Circle One): DOCTOR CASE TEMP.TOTAL LOST TIME PER. PARTIAL DISABILITY FATAL

PRIMARY CAUSE OF INCIDENT:

HAS REASONABLE CORRECTIVE ACTION BEEN TAKEN? YES ☐ NO ☐

COMPLETED BY:

ATTACHMENT 5.2 (FIRST REPORT OF INJURY - POLICE DEPARTMENT ONLY)

PART I
(completed by supervisors)

SACRAMENTO POLICE DEPARTMENT

FIRST REPORT OF INJURY

INSTRUCTIONS: The supervisor will complete this report for each injury which does not require skilled medical attention and forward the completed report to the Personnel and Training Section.

NAME_____ AGE_____ CLASSIFICATION_____

DATE OF INCIDENT_____ TIME_____ DATE REPORTED_____ TIME_____

ADDRESS OR LOCATION OF INCIDENT_____

WITNESSES:_____

TYPE OF INCIDENT (CHECK ALL APPROPRIATE BOXES)

- ☐ ACCIDENTAL CONTACT W/FOREIGN OBJECT
- ☐ SLIP/FALL (SAME LEVEL)
- ☐ FALL (DIFFERENT LEVEL)
- ☐ RESCUE
- ☐ USING HAND TOOL
- ☐ ATHLETIC ACTIVITY
- ☐ VEHICLE ACCIDENT
- ☐ PURSUIT-FOOT (UNLESS CHECKED ABOVE)
- ☐ VEHICLE ACCIDENT (CODE 3)
- ☐ LIFTING/PUSHING/ PULLING OBJECT
- ☐ HANDLING EQUIPMENT
- ☐ FOREIGN BODY/EYE
- ☐ HANDLING RESISTING SUSPECT
- ☐ OTHER_____

CHECK ALL CATEGORIES (YES OR NO)

UNSAFE ACT	☐ NO	☐ YES	DISREGARD OF INSTRUCTIONS	☐ NO	☐ YES
UNSAFE CONDITION (If yes, explain)	☐ NO	☐ YES	UNSAFE ACT OF ANOTHER	☐ NO	☐ YES
HAS PROBLEM BEEN CORRECTED	☐ NO	☐ YES	CONTRIBUTING FACTORS	☐ NO	☐ YES
ADEQUATE LIGHT	☐ NO	☐ YES	OTHER FACTORS	☐ NO	☐ YES
INATTENTION	☐ NO	☐ YES			

NATURE OF INCIDENT/COMPLAINT(DESCRIBE INJURY)

HOW? Explain:_____

SUPERVISOR'S SIGNATURE

PART II(completed by City Safety Officer)

PRIMARY CAUSE OF INCIDENT:_____

HAS REASONABLE CORRECTIVE ACTION BEEN TAKEN? _____ YES _____ NO

SPD 168 (Rev. 12-80)

CITY SAFETY OFFICER

ATTACHMENT 5.3 (REPORT OF INDUSTRIAL INJURY - Form DPM-400)

CITY OF SACRAMENTO
REPORT OF INDUSTRIAL INJURY

COMPLETE THIS REPORT IN TRIPLICATE IMMEDIATELY ON ALL INJURIES TO EMPLOYEES OF THE CITY WHICH REQUIRE THE SERVICES OF A PHYSICIAN OR RESULT IN LOSS OF TIME BEYOND THE DATE OF INJURY AND DISTRIBUTE AS FOLLOWS:
① WHITE COPY - TO BE TAKEN BY INJURED EMPLOYEE TO TREATING PHYSICIAN; ② BLUE COPY - FORWARD TO SAFETY OFFICER
③ PINK COPY - EMPLOYEE'S DEPARTMENTAL PERSONNEL FILE

NOTE: FATALITIES MUST BE REPORTED **IMMEDIATELY** BY PHONE TO 449-5741

Please TYPE OR PRINT - WRITE ON FIRM SURFACE

EMPLOYEE

LAST NAME | FIRST NAME | MI | FOA

HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | HOME PHONE

DATE OF BIRTH | AGE | HIRE DATE | MONTHS OF SERVICE | EMPLOYEE CLASSIFICATION TITLE | EMPLOYEE'S DEPT/DIV - ORG. NUMBER

INJURY

DATE OF INJURY | TIME OF INJURY AM ☐ PM ☐ | DATE INJURY REPORTED | TIME INJURY REPORTED AM ☐ PM ☐ | ADDRESS OR LOCATION WHERE INJURED | ON CITY PROPERTY YES ☐ NO ☐

ON CITY BUSINESS YES ☐ NO ☐ | DESCRIPTION INJURY (SCRATCH, CUTS, ETC.) | FATAL YES ☐ NO ☐ | PART OF BODY INJURED | SIDE INJURED RIGHT ☐ LEFT ☐ BOTH ☐

CAUSE OF INJURY

HOW DID INJURY HAPPEN? (STATE ALL DETAILS)

SPECIFY MACHINE, TOOL OR OBJECT MOST CLOSELY CONNECTED WITH ACCIDENT

WHAT WAS EMPLOYEE DOING WHEN INJURY OCCURRED?

WITNESS(es) TO INJURY

INVESTIGATION

WHAT UNSAFE ACT/CONDITION CONTRIBUTED TO INJURY?

WHAT SAFETY EQUIPMENT WAS USED; IF NONE, COULD EQUIPMENT HAVE PREVENTED INJURY?

EMPLOYEE'S IMMEDIATE SUPERVISOR (SIGNATURE) | OTHER COMMENTS, IF ANY

TREATMENT

ATTENDING PHYSICIAN | ADDRESS | ZIP CODE | PHONE

IF HOSPITALIZED, NAME OF HOSPITAL | ADDRESS | ZIP CODE | PHONE

OTHER TREATMENT INFORMATION, IF ANY

DIVISION CHIEF'S COMMENTS (INCLUDE MEASURES TO PREVENT RECURRANCE)

DATE COMPLETED | COMPLETED BY (SIGNATURE) | DEPT. HEAD/DIV. CHIEF REVIEW (SIGNATURE) | DATE