

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. Slupe*
City Manager

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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.

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

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 <input type="checkbox"/>	EXPLAIN:
UNSAFE CONDITION <input type="checkbox"/>	

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. LOST TIME	TOTAL PER. PARTIAL DISABILITY	FATAL
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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)

- | | | |
|---|---|---|
| <input type="checkbox"/> ACCIDENTAL CONTACT
W/FOREIGN OBJECT | <input type="checkbox"/> ATHLETIC ACTIVITY | <input type="checkbox"/> HANDLING EQUIPMENT |
| <input type="checkbox"/> SLIP/FALL
(SAME LEVEL) | <input type="checkbox"/> VEHICLE ACCIDENT | <input type="checkbox"/> FOREIGN BODY/EYE |
| <input type="checkbox"/> FALL (DIFFERENT LEVEL) | <input type="checkbox"/> PURSUIT-FOOT
(UNLESS CHECKED ABOVE) | <input type="checkbox"/> HANDLING RESISTING SUSPECT |
| <input type="checkbox"/> RESCUE | <input type="checkbox"/> VEHICLE ACCIDENT
(CODE 3) | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> USING HAND TOOL | <input type="checkbox"/> LIFTING/PUSHING/
PULLING OBJECT | |

CHECK ALL CATEGORIES (YES OR NO)

- | | | | | | |
|---------------------------------------|-----------------------------|------------------------------|---------------------------|-----------------------------|------------------------------|
| UNSAFE ACT | <input type="checkbox"/> NO | <input type="checkbox"/> YES | DISREGARD OF INSTRUCTIONS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| UNSAFE CONDITION
(If yes, explain) | <input type="checkbox"/> NO | <input type="checkbox"/> YES | UNSAFE ACT OF ANOTHER | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| HAS PROBLEM BEEN CORRECTED | <input type="checkbox"/> NO | <input type="checkbox"/> YES | CONTRIBUTING FACTORS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| ADEQUATE LIGHT. | <input type="checkbox"/> NO | <input type="checkbox"/> YES | OTHER FACTORS | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| INATTENTION | <input type="checkbox"/> NO | <input type="checkbox"/> 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

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
DATE OF BIRTH		ACT	HIRE DATE	EMPLOYEE'S CLASSIFICATION TITLE	EMPLOYEE'S DEPT./DIV. ORG. NUMBER		
INJURY	DATE OF INJURY	TIME OF INJURY AM <input type="checkbox"/> PM <input type="checkbox"/>		DATE INJURY REPORTED	TIME INJURY REPORTED AM <input type="checkbox"/> PM <input type="checkbox"/>		ADDRESS OR LOCATION WHERE INJURED
	ON CITY BUSINESS YES <input type="checkbox"/> NO <input type="checkbox"/>	DESCRIPTION OF INJURY (SCRATCH, CUTS, ETC.)				FATAL YES <input type="checkbox"/> NO <input type="checkbox"/>	PART OF BODY INJURED
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 REOCCURRENCE)							
DATE COMPLETED	COMPLETED BY (SIGNATURE)			DEPT. HEAD/DIV. CHIEF REVIEW (SIGNATURE)		DATE	