INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

Approved by:

Name: Joseph Tanner, City Manager

Date: June 24, 2020

TABLE OF CONTENTS

Contents

SAFETY POLICY AND MANAGEMENT COMMITMENT

It is the policy of the City of Lindsay to maintain a safe and healthful workplace for all employees. This safety policy applies to all business operations and functions including those situations where employees are required to work off-site.

The City of Lindsay recognize the value of their employees and are committed to ensure compliance with “A Safe and Healthy Workforce”, as well as all applicable federal and state regulations, and City policies and programs; demonstrate visible and active leadership in all of our business activities by providing resources necessary to manage and communicate safety commitment, expectations, and accountability; provide the required safety trainings; implement proactive hazard identification and follow through with the elimination and control of identified hazards. Keeping safety and wellness as an integral part of all operations, we will be able to better identify, reduce or eliminate on-the-job hazards and unsafe work practices in our workplace.

In this endeavor, this Injury and Illness Prevention Program (IIPP) has been developed for our employees so that safety is given primary consideration for all work conducted. The IIPP will pursue its objective through the effective implementation of the following elements:

- Safety Responsibilities
- Employee Compliance
- Safety Communication
- Hazard Assessment and Inspection
- Hazard Correction
- Accident/Exposure/Near-Miss Investigation
- Training and Instruction
- Recordkeeping

Department Directors have been appointed the Chief Safety and will serve as the departmental liaison to the IIPP Chairperson and other departments/offices with respect to all matters related to employee safety and health and will have the overall authority and responsibility for implementing this IIPP. A Department Safety Coordinator will be appointed by each Department Director and this Coordinator is responsible for the day-to-day implementation of the department’s IIPP. All employees are expected to adhere to this IIPP and work diligently to maintain safe and healthful working conditions.

SAFETY RESPONSIBILITIES

Each person at the department plays an important role in maintaining a safe and hazard-free work environment. To ensure that the safety program remains effective, the following specific responsibilities are required:

Head of Department Responsibilities

- Designate a senior manager as the Chief Safety
- Incorporate supervisors' safety efforts and safety performance into performance evaluations
- Serve as or designate an individual to serve as the IIPP Implementation Plan Administrator
- Oversee and support the components outlined in this program
- Authorize the allocation of physical and financial resources necessary to maintain an effective IIPP
- Ensure the IIPP is reviewed and updated annually as appropriate and electronic copies are provided to the Human Resources Manager of the Personnel Department

Chief Safety Responsibilities

- Serve as liaison to the Head of the Department, the Personnel Department and other Department offices with respect to matters related to workers' safety and wellness
- Provide assistance with safety compliance components of this IIPP
- Ensure safety and wellness data entry and updates are maintained in regulatory compliance
- Enforce all applicable safety and health regulations as required to comply with this IIPP
- Serve as a contact for the IIPP Chair Person(s)
- Consult with the Human Resources Manager of the Personnel Department to ensure the IIPP complies with Cal/OSHA
- Ensure that the IIPP is tailored to meet the specific needs of the Department/Office
- Oversee the tracking of safety incidents and that appropriate corrective actions have been taken
- Oversee that an accident investigation is conducted and that a corresponding accident investigation form is completed for all injuries
- Ensure that the Employee Safety Committee has been established
- Ensure that safety and compliance data, OSHA correspondence and citations are provided to the Human Resources Manager of the Personnel Department in a timely manner upon request
- Distribute a memorandum to the Risk Management and Human Resources Director, in the event of a fatality/serious injury or illness. Said memorandum briefly describes the incident and confirms that Cal/OSHA and the City Manager were made aware of the incident as soon as reasonably able.

  Contact Information for the Local Cal OSHA:
  2550 Mariposa Street, Rom 4000, Fresno, CA 93721
  Tel: 559-445-5302 & Fax: 559-445-5786

Department Safety Officers/ Supervisors Responsibilities

- Provide support, leadership and direction for the IIPP
- Adopt policies, standards, and procedures that include the written Code of Safe Practices to ensure that activities and operations within the department/division/office/group are conducted safely and comply with applicable local, state, federal regulations and City policies
- Ensure the development of a project-specific Code of Safe Practices when City employees are involved in construction work, and that the project-specific Code of Safe Practices is posted or is provided to each supervisory employee who shall have it readily available at the construction job

site
- Provide financial support for completion of the provisions outlined in this program
- Assist managers in pursuing disciplinary action against employees who violate health and safety rules and guidelines
- Actively promulgate and support a system for communicating with employees on matters relating to employee health and safety through safety committees, or any other means that ensure effective communication and acknowledgement by employees
- Ensure that, in compliance with City policy, an accident investigation and corresponding Accident Investigation Form is completed when there is a safety incident or workers' compensation claim filed
- Ensure that the Department Coordinator and/or Human Resources Manager is notified when Cal/OSHA, or any other health and safety regulatory agency, arrives on-site or the Department receives any written inquiry from them
- Through discussion with supervisors, evaluate the effectiveness of implementing the IIPP and provide recommendations for improvement to the department's Coordinator and/or Human Resources Manager
- Ensure their offices maintain and post occupational injury statistics (Cal/OSHA Forms 300 and 300A)
- Designate a coordinator to track and prepare the occupational injury statistics (Cal/OSHA Forms 300 and 300A)
- Establish and support an Employee Safety Committee
- Ensure that all required safety equipment is available for use

Department Directors and Supervisors Responsibilities

- Familiarize themselves with City and departmental safety policies, programs, and procedures
- Ensure effective implementation of this IIPP within their department or unit
- Ensure that employees who require training pursuant to City, department, and or regulatory requirements receive appropriate training in a timely manner
- Ensure that all safety and health policies and procedures, including this IIPP, are clearly communicated to and understood by employees
- Consistently and fairly follow and enforce all state, City and department safety rules
- Inspect work areas on a periodic basis to ensure compliance with applicable health and safety rules and regulations
- Investigate or facilitate the appropriate investigation of safety concerns or accidents that occur on the job within their department or unit
- Conduct prompt and thorough investigation of every safety incident, accident or near-miss to determine cause and prevent recurrence
- Based on the results of an authorized investigation, work in conjunction with the Human Resources Manager and Department Director to implement appropriate disciplinary measures in accordance with City practice and negotiated labor contract provisions
- Encourage employees to report workplace hazards and emphasize that such reporting may be done without fear of reprisal
- Report questionable incidents and/or injuries which may involve fraud to the Department Director or Human Resources Manager
- Ensure that corrective actions are taken to prevent recurrence
- Ensure that all health and safety hazards are documented and that appropriate personnel are notified for corrective action/abatement
- Maintain safety training records for their employees

- Maintain a current list of hazardous chemicals and the respective Safety Data Sheets (SDS) for ones to which their employees may be exposed

Employees Responsibilities

- Work safely and assist coworkers and other to work safely
- Follow department's, manager's and supervisor's safety directives
- Comply with the provisions of this written plan and department's Code of Safe Practices
- Obtain clarification on any provision in this Plan that they do not understand
- Report to work in the necessary mental and physical condition to perform the essential functions of their job
- Inform supervisors if there is a reason they are unable to perform the essential functions of their job
- Wear appropriate safety equipment as required when performing job duties
- Maintain equipment in proper working order and good condition
- Immediately report all injuries, accidents and near-misses, no matter how minor, to their supervisor
- Report unsafe acts, work practices and working conditions without fear of reprisal
- Complete the necessary health and safety training, as directed by their supervisors, managers and department for their job
- Maintain their work area in a safe and healthful condition
- Cooperate fully with all authorized investigations regarding accidents and safety practices

EMPLOYEE COMPLIANCE WITH SAFE WORK PRACTICES

An effective safety program requires the cooperation and compliance of all employees. Management is responsible for ensuring that all safety and health policies and procedures are clearly communicated and understood by all employees, and enforced fairly and uniformly. To ensure that all employees comply with department rules and maintain a safe work environment, our compliance system includes one or more of the following practices:

- Informing employees of the provisions of our IIPP Evaluating the safety performance of all employees
- Recognizing employees who perform safe and healthful work practices Providing training to employees whose safety performance is deficient
- Disciplining employees for failure to comply with safe and healthful work practices

All employees will be provided with department's Code of Safe Practices as set forth in this document (Attachment B). Employees will be required to comply with the Code of Safe Work Practices.

SAFETY COMMUNICATION

Communication is an essential element of an effective safety program. Management, supervisors and employees are encouraged to clearly communicate and act upon safety and health questions or concerns without fear of reprisal. Communication of safety issues is to be in a form that is readily understandable by all affected employees.

In addition to the department/employee Safety Committee, effective communications with employees

have been established using one or more of the following methods:

Tailgate/pre-job meetings	Posters and warning labels
Specific policies/procedures	Safety newsletter, handouts
Department hazard assessment	Anonymous hazard notification
Employee safety training	Staff Meetings
Bulletin Boards	Safety Committee Minutes

All managers and supervisors are responsible for communicating with all employees about occupational safety and health in a form readily understandable by all employees.

The Employee Safety Committee is established to assist with the open sharing of knowledge and to respond to questions from employees in a timely manner. Attachment A provides guidelines to develop an effective Employee Safety Committee.

Our communication system encourages all employees to in

their managers and supervisors about workplace hazards without fear of reprisal. Employees can also contact the Department Director, Supervisor, Human Resources Manager and or the City Manager to report any workplace hazards directly or anonymously. Copies of Safety Concern or Suggestion Form (FORM 1) will be provided to facilitate an employee's report. Under no circumstances will employees be disciplined or subjected to any form of reprisal for legitimately reporting a hazard.

Employee safety bulletin boards are located at various locations where employees routinely congregate. Employees are encouraged to become familiar with the location of, and the materials posted on, the bulletin boards such as:

- "Safety and Health Protection on the Job" (Cal/OSHA)
- "Treatment and Reporting of On-duty Injuries to Civilian Employees" (Workers' Compensation, City of Lindsay Human Resources Department)
- "Access to Medical and Exposure Records" (Cal/OSHA)
- "Emergency Phone Numbers" (Cal/OSHA Form S-500)
- Responses to corrected unsafe conditions (FORM 2 - Hazard Abatement Form)
- "Whistleblowers Are Protected" (Labor Code Section 1102.8)
- Current safety meeting minutes
- Summary of Work-Related Injuries and Illnesses (Form 300A) (posted from February 1st to April 30th of each year)

HAZARD ASSESSMENT AND INSPECTION

The primary reason for conducting hazard assessments and facility safety inspections is to identify and control hazards, unsafe conditions, and unsafe work practices. Controlling hazards minimizes the risk to employees and helps to prevent accidents and injuries.

The department will conduct hazard assessments and facility safety inspections once per quarter and additionally when one or more of the following conditions occur:

- When the IIPP is established
- When new equipment creates an unsafe condition

- When a product, process or procedure creates a hazard or unsafe condition
- When new or previously unrecognized hazard or unsafe condition is identified
- When an occupational injury or illness occurs
- When a workplace condition warrants an inspection

Walkthrough safety inspections or assessments will be conducted by one or more of the following:

Managers and Supervisors
Employee Safety Committee
Employees or a designee

Employees are encouraged to use Hazard Assessment (Form 8) and Safety Inspection Checklist Form(s) (FORM 7) when conducting formalized walkthrough inspections.

The completed Hazard Assessment and Safety Inspection Checklist Form(s) - will be forwarded to the Department Safety Coordinator. The Department Safety Coordinator will track identified concerns or hazards from such inspection records until resolved. An update will be provided to both the Employee Safety Committee and IIPP Chairperson in a timely manner.

HAZARD CORRECTION

It is the department's intention to eliminate workplace hazards and unsafe work practices as soon as feasible. However, some corrective actions may require more time. Hazards that cannot be immediately corrected/abated will be prioritized based on the following considerations among others:

Probability and severity of an injury or illness resulting from the hazard
Availability of needed equipment, materials and/or personnel
Time for delivery, installation, modification, or construction
Training periods

While corrective action is in process, necessary precautions are to be taken by the department to protect or remove employees from exposure to hazards.

When an imminent hazard exists that cannot be immediately abated without endangering employee(s) and/or property, all exposed employees are to be evacuated from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition are to be provided with the appropriate training and required personal protection equipment.

The department will use the Hazard Assessment and Safety Inspection Checklist Form 7 and Hazard Abatement Form 2 as appropriate to describe the measures taken to abate hazards or unsafe work practices. The completed forms will be forwarded to the Safety Coordinator for tracking identified concerns or hazards until resolved.

ACCIDENT/INCIDENT/NEAR-MISS INVESTIGATION

Accident, incident, and near-miss investigations are performed in order to gather information on the

cause(s) that contributed to the occurrence. This information is useful in determining corrective actions that can be taken to prevent the same type of incident from recurring. Investigations are to be documented and the results communicated to all affected employees.

The department has the responsibility to investigate all work-related accidents, incidents, and near-misses and make any necessary hazard corrections to prevent recurrence.

Employees must immediately report all work-related accidents, incidents, or illnesses to their supervisor, using the Employee's Report of Injury/Illness Form (FORM 5), unless the employee is unable to do so. In this case, the notification must be made by a lead worker or co-worker, or the employee as soon as possible thereafter. Upon becoming aware of an employee injury or illness, the supervisor or designated staff shall:

- Assess the need for medical attention:
    - If injuries appear to be critical, dial (911) for immediate emergency services
    - If urgent medical treatment is required or if the employee is in immediate danger, the employee should be taken to the nearest hospital emergency room
    - If the injury or illness is not a medical emergency, but requires further medical treatment, direct the employee to call the 24/7 Nurse Triage Hotline:
        - 1-844-691-4111
    - If the injury only requires First Aid, provide First Aid to the employee using the workplace First Aid kit
- Provide the injured with FORM 4 Package. The package includes employee's, supervisor's, witness' reports & informational items;
    - 4A-The Nurse injury Hotline Flyer (Employee Information Only)
    - 4B-Form 5020 Employer's Report of Occupational injury or illness (Completed by Supervisor & Risk Management)
    - 4C-Worker's Compensation Claim Form (CWC1) & Notice of Potential Eligibility (Completed by Employee and Supervisor)
    - 4D-Supervisor's Accident Report (Completed by Supervisor)
        - Visit the accident/incident scene and initiate investigation by interviewing the injured employee and witnesses; examine the accident/incident area (take pictures, measurements, etc.) as soon as possible in order to identify the "who, what, why, where and when"
    - 4E-Employee's Report of Injury (Completed by Employee)
    - 4F-Accident Witness Statement (Completed by Witness, if any)
    - 4G-The City of Lindsay Workers' Compensation Benefits (Employee Information Only)

- Forward all completed original forms to Risk Manager for review and recordkeeping as necessary

Serious Injury and Fatality

For accidents that result in a fatality or a serious injury, the supervisor or designated staff must:

- Immediately notify the Risk Management Representative, AIMS and City Safety Administrator.
- Per the direction of the Risk Management, immediately after knowledge of the incident, report the serious injury and fatality to the nearest Cal/OSHA District office: 2550 Mariposa Street, Room 4000, Fresno, CA 93721
  Tel: 559-445-5302 & Fax: 559-445-5786

Form 3, Cal/OSHA Accident Reporting Worksheet, provides a list of information that will be needed before placing a call to the Cal/OSHA District Office to report serious injury and/or fatality.

Vehicle Accidents

Any employee involved in a vehicle traffic accident involving City or privately-owned mileage vehicles operated on City business shall report the accident immediately to his/her supervisor and the Police Department for investigation. The employee must remain at the accident location until the police arrive to investigate. The supervisor/employee must complete all appropriate forms in FORM 4 package and submit a copy of the police report. Public safety will provide a vehicle report or request an outside agency to perform it.

Log of Work-Related Injuries and Illnesses

The department maintains its own injury/illness log using the following Cal/OSHA forms as listed below:

- Cal/OSHA Form 300 (Log of Work-Related Injuries and Illnesses)
- Cal/OSHA Form 300A (Summary of Work-Related Injuries and Illnesses)
- Cal/OSHA Form 301 (Injury and Illness Incident Report)

Said log is to document work-related injuries and illnesses caused by an event or exposure that results in employee death, loss of consciousness, one or more days away from work, restricted duty, job transfer, medical treatment beyond First Aid or a significant injury or illness diagnosed by a physician or other licensed health care provider.

The Department Director maintains and tracks such occupational injury statistics and provides them to the Human Resources Manager. At the end of each calendar year, the Department Director or Human Resources Manager or designated staff prepares an annual summary of injuries and illnesses that occurred during that calendar year (Form 300A). This annual summary is posted in a conspicuous location from February 1 until April 30.

Near-Miss Incident

Employees must immediately report all work-related near-miss incidents to their supervisor. For all near-miss incidents reported (regardless of the outcome), the supervisor or designated staff shall document the incident and immediately conduct an investigation using the Near-Miss Reporting and Investigation Form (FORM 5). Any unsafe acts or conditions identified during the investigation must be corrected and results effectively communicated to prevent future occurrence of similar incidents. The completed Near-Miss Form will be forwarded to the Department Director and Human Resources Manager for further review and recordkeeping. This documentation will be brought before the IIPP Committee for review.

TRAINING AND INSTRUCTION

The department shall ensure compliance with Cal/OSHA and City of Lindsay health and safety training requirements and shall ensure employees receive regular and effective communication regarding safety training and safety programs, rules and regulations.

Employee training shall be offered under, but not limited to, the following circumstances:

- To all employees new to the City and/or to a particular work assignment, unless the employees provide documentation and/or proof of current valid training (e.g., a Certificate of Training from another employer or agency)
- To all employees with respect to hazards specific to their job assignment
- To supervisors and/or managers when necessary to familiarize them with the safety and health hazards to which workers under their immediate direction and control may be exposed

Whenever new equipment, substances, processes, and procedures are introduced to the workplace which may pose or represent a new hazard or non-routine hazard

- Whenever the department is made aware of a new or previously- unrecognized hazard
- As required by other agencies (e.g., Department of Motor Vehicles (DMV), Department of Transportation (DOT), etc. for continuing education and/or certification for employee to function on behalf of the City

In addition to the above, and at a minimum, workplace health and safety training and practices for all City employees shall include, but not be limited to, the following:

- Explanation of the City's IIPP
- Emergency Action Plan
- Instructions on how to report anyunsafe conditions, work practices, and injuries
- Explanation of what to do when additional instruction is needed
- Job specific instructions regarding non-routine hazards unique to a job assignment, to the extent that such information was not already covered in other trainings
- Information about chemical hazards to which employees may be exposed
- Information regarding other hazard communication programs
- Information regarding the provision of medical services and First Aid, including emergency procedures
- Information regarding the name, telephone number, and location of the medical clinic and nearby hospital where employees should be taken for treatment

Safety and health training must be documented in writing for each employee. Health and Safety Training Form 6 will be utilized to document employee training. The completed training forms will be forwarded to Safety Coordinator for recordkeeping purposes.

RECORDKEEPING

The department shall ensure compliance with Cal/OSHA and City recordkeeping requirements.

Records that document implementation of the IIPP shall be maintained in the department's central safety files. These files are located at the Human Resources Managers Office central files. The following records will be maintained for at least the period indicated:

The written IIPP	**Indefinitely**
Completed Inspection and Abatement Forms – Minimum 1 Year	**1 years**
Completed Investigation	**3 years**

Employee Training Records – Minimum 1 Year	**3 years**
Records relating to employee communication and enforcement:	
Employee Safety Committee Meeting Minutes & Sign-up Sheets	**3 years**
Employee Suggestion/Question and Responses	**3 years**
Cal/OSHA 300,300A, & 301 forms	**5 years**
Medical and employee exposure records	**Duration of employment plus 30 years**

DEFINITIONS

Near-Miss Incident is an unplanned event that did not result in an injury and/or illness but had the potential to do so.

Serious Injury/Illness means any injury or illness occurring in a place of employment or in connection with any employment which requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

PERFORMANCE MONITORING

The IIPP Chairperson shall conduct an annual review of the program and update as appropriate. This review includes assessing any new regulatory requirements or changes to existing regulatory requirements, and identifying any opportunities for improvements to the program.

REVIEW/REVISION HISTORY

Rev.	Date	Description of Revision	Contact

ATTACHMENT A-GUIDELINES TO DEVELOPING EMPLOYEE SAFETY COMMITTEE

The primary objective of the Employee Safety Committee is to provide support to enhance and administer the City's overall Safety Program. The Committee will also assist in maintaining a safe place of employment by ensuring that work is performed in a manner that provides the highest level of safety for employees.

Employee Safety Committee allows Departments/Offices to take an overall look at safety requirements and to take proactive measures towards safety hazards and deficiencies. The Committee is also a visible and approachable body for safety complaints, suggestions, and the like. Safety committee members assist senior management and make recommendations for change.

GENERAL ORGANIZATION

Safety Committees range in size and structure based on the organization's number of employees, worksites and hazards present. Safety Committees should have representation from all divisions/sections. The person who serves on a Safety Committee should have familiarity with the operations and functions affecting their divisions/office/groups.

FUNCTION

Safety Committee's typical duties include: developing safe work practices, developing written safety programs, facilitating safety training, conducting and/or reviewing safety inspections, and accident investigations. The Committee can also help promote other activities that encourage employees to support the organization's safety program. The following is a more detailed description of a Safety Committee's various duties and responsibilities:

- Committee may review all accident/incident reports, hazard assessment, safety suggestions, and make recommendations or suggestions to prevent their recurrence. The Committee will also follow upon all safety recommendations/resolutions to ensure they have been acted upon and appropriately recorded.
- All recommendations, safety suggestions, complaints, unsafe condition reports and other hazard reports can be assigned to a member for action.
- Members may monitor safety inspections conducted in their respective division/section. They may also review investigations of occupational accidents and causes of incidents resulting in occupational injury, occupational illness, or exposure to hazardous substances.
- Committee members should bring all safety-related matters to the attention of Department/Office management and supervision for correction prior to being brought up at a Committee meeting.

- Upon request from Cal/OSHA, Committee will verify abatement action taken by the employer to abate citations issued by the Cal/OSHA.

RECOMMENDED PROCEDURES

- Committee should function with a Committee Chair and Vice-chair. Department/Office's Safety Coordinator may preside the meeting.
- Meetings should be held regularly, but not less than quarterly, and should follow a consistent schedule.
- Meeting agendas should be published in advance.
- Meetings can be conducted in accordance with Robert's Rules of Order.
- Meeting minutes should summarize the issues discussed, the proposed actions to be taken, and the person(s) responsible for follow-up on each item. Minutes should be published and provided to each Committee member, as well as be made available to all employees.
- Members are required to attend all meetings, except in case of emergency. If a member cannot attend a meeting, then an alternate should be sent. Attendance will be taken at each meeting and will be recorded in the minutes.
- Committee meeting minutes shall be maintained for at least one year.

ATTACHMENT B- DEPARMENT CODE OF SAFE PRACTICES FOR OFFICE AREAS

1. Each staff member is to observe safe working methods and procedures and assist in acquainting new staff members with our concerns for safety.

2. Office equipment is to be arranged in such a manner as to provide safe working conditions.

3. Unskilled persons are not permitted to operate or tamper with office machines.

4. Un-jamming and servicing photocopy machines present electrical hazards and exposure to hot surfaces. Only specifically trained staff members are to open or service the copy machines.

5. Office machines and their cords are to be guarded as needed and required by law or regulation. Telephone cords and electrical cords to computers or other equipment are to be maintained in such a manner as will present no tripping hazard. Frayed or badly worn cords are to be replaced. Cords should not be allowed to come in contact with heat-producing equipment, such as portable heaters. When unplugging any appliance, pull by the plug, not the wire.

6. Overhead storage should be prevented or minimized when possible.

7. Machines are never to be cleaned or adjusted while in operation. If appropriate, the electrical power shall be disconnected.

8. Equipment or machines in need of repair are to be removed from service immediately and not returned to use until properly repaired.

9. Installation, repair, or maintenance of any office equipment is to be done only by qualified persons.

10. Hand paper cutters are to have the blade in the down position, at all times, when not in use. If the blade guard is missing, take the cutter out of service.

11. Filing cabinets and bookcases shall be sufficiently secured to the floor or wall to prevent tipping during earthquakes.

12. When not in actual physical use, all desk and file drawers are to be kept closed so as to avoid tripping hazards or limiting safe use of aisles. Not more than one file drawer in one file cabinet shall be opened at one time. Opening additional drawers could over-balance the file, causing all of the drawers to roll out on the staff member. Staff members are not to stand on or in an open file drawer as a means of reaching higher objects.

13. Ladders or step stools of adequate design to support the staff member's weight and the material to be obtained are provided and readily available as a means of reaching high files and upper locker and/or storeroom shelves. No staff member is to stand on a box, table, desk, swivel or folding chair for any such purpose. Reaching above shoulder height should be avoided.

14. All hazards, such as sharp file cabinet edges, splintered wood furniture or any other conditions likely to do bodily harm, damage clothing, or constitute a fire hazard shall be reported to your supervisor.

15. Wastebaskets are provided as receptacles for waste paper only.

16. Aisles are to be kept clear of obstructions at all times.

17. Work areas to be kept clean and in orderly fashion.

18. Personal protective equipment such as goggles and hearing protection will be provided as necessary based on a Hazard Evaluation from the Department Coordinator. It is to be worn when and where prescribed.

19. Machine guards or other safety devices on machinery shall not be removed or by-passed in any way.

20. Hazardous chemicals are to be used only for their intended purpose and in the manner prescribed on their labels. Protective equipment required by labels is to be worn. Employees are not permitted to bring hazardous chemicals or products from home to use at work (e.g., bug spray, nail polish remover, cleaning products).

21. Report all unsafe conditions, work-related accidents, near-misses, injuries or illnesses to your supervisor.

22. In the event of fire, immediately notify all co-workers according to the procedures outlined in the Building Emergency Plan.

23. Upon hearing the fire alarm, stop work immediately and proceed to the nearest clear exit. Gather in the safe refuge area so attendance may be taken to account for all employees.

24. Means of egress are to be kept clear, well lighted and unlocked during working hours.

25. Staff members are not to store excessive combustibles (paper) in work areas.

26. Aisles and hallways are to be kept clear at all times.

27. Workplaces are to be kept free of debris, floor storage and trip hazards (e.g., electrical cords in walkways).

28. Staff members must exercise caution when moving about the office. Do not read while walking from one place to another. When walking around corners, slow down and look around corner. Do not carry pencils/pens with sharp points protruding from your pockets.

29. Cups are to be covered if taken from one area to another. Spills create slip hazards and must be cleaned up immediately.

30. Do not lean excessively back in a chair. The chair can tip over.

31. Lift with your legs, not your back. For heavy objects use a handcart or get help.

32. Always turn off electricity to equipment before performing maintenance or replenishing supplies.

33. Pull paper cutter blade to closed position and latch when you are through using the paper cutter.

34. When not in use, retract carton cutter blades.

35. When clearing jams in copying machines, do not rest your arms inside the machine where a burn hazard may exist.

36. Adequate lighting to be provided throughout the work areas.

.

FORM 1-SAFETY CONCERN OR SUGGESTION REPORT

If the safety concern creates a hazard to employees and needs immediate attention, please notify your supervisor or contact the Department Coordinator or Human Resource Manager. All personal information contained on this form is confidential.

Name: _____ (OPTIONAL) Phone Number: _____ (OPTIONAL)

Site or Facility Address: _____ Date: _____

Include a brief description of the safety concern or safety suggestion; include the location in which it can be investigated.

Has this safety concern been brought to the attention of your supervisor?

Yes ☐ No ☐ If yes, date notified: _____

Was Administrative Services Division notified regarding safety-related repairs?

Yes ☐ No ☐ If yes, date notified: _____

Do you want the Safety Staff to contact you?

Yes ☐ No ☐ If yes, please include your name and phone number above.

Please indicate your preference: ☐Do not reveal my name to my supervisor

☐ My name may be revealed to my supervisor

FORM 2-HAZARD REMOVAL/ABATEMENT

You may identify hazardous conditions. The next step is to eliminate these hazards. Use this form to record actions taken to correct hazards.

Date:	
Area inspected:	
Identified hazard or concern:	
The steps to be taken to remove hazard:	
Priority:	**Deadline for removing hazard (date):**
High____Medium____Low ____	
Hazard has been successfully removed/abated on (date):	
Notes:	
Supervisor's signature:	**Date:**

FORM 3-CAL/OSHA ACCIDENT REPORTING WORKSHEET

Employers must immediately report to Cal/OSHA any work-related death or serious injury or illness.	
Date of call placed to Cal/OSHA:_____ Time:_____ ☐a.m. ☐p.m. Cal/OSHA District Office name and phone no:_____	
When reporting serious injury/fatality to Cal/OSHA, have the following information on hand:	
Time and date of accident/event:	
Employer's name, address and telephone number:	
Name and job title of the person reporting the accident:	
Address of accident/event site:	
Name of person to contact at accident/event site:	
Name and address of injured employee(s):	
Nature of injuries:	
Location where injured employee(s) was/were taken for medical treatment:	
List and identity of other law enforcement agencies present at the accident/event site:	
Description of accident/event and whether the accident scene or instrumentality has been altered:	
You must request the following information from the Cal/OSHA operator or representative:	
Name of Cal/OSHA operator or representative:	
Cal/OSHA Case/Report #:	

FORM 4- ACCIDENT INVESTIGATION REPORT

Accident investigation forms/statements consist of the A) The Company Nurse Injury Hotline Flyer, B) FORM 5020 Employer's report of occupational injury or illness, C) Workers' Compensation Claim Form (CWC 1) & Notice of Potential Eligibility, D) Supervisor's Accident Investigation, E) Employee's Report of Injury, F) Accident Witness Statement, and G) the City of Lindsay Workers' Compensation Benefits. The supervisor should provide these to the appropriate individuals for completion after any accident or near miss incident that could have resulted in an accident.

IMPORTANT - Obtaining statements as soon as possible following an accident insures that the employer has an accurate account of how the injury occurred, helps correct hazards to prevent the accident from recurring, and assures the employee's claim is documented.

After I have these forms completed, what do I do with them?

1. **For all accidents or near miss incidents** (regardless of the outcome): the supervisor should complete any corrective actions identified during the investigation to prevent recurrence of the incident and document this on the Supervisor's Accident Investigation form. The supervisor should also keep copies of all the forms for future reference.
2. **For all accidents that result in the employee filing a workers' compensation claim**: in addition to step 1 above,
   - Submit a copy of these forms to the Finance Department for their retention.
   - The Finance Department will submit a copy of these forms to the Acclamation Insurance Management Services (CSJVERMA) Workers' Compensation Division along with the Employer's Report of Occupational Injury or Illness (Form 5020) and the Workers' Compensation Claim Form (DWC 1).
   -

Risk Management Attn: Mari Carrillo 251 E. Honolulu Lindsay, CA 93247 559-562-7102 xt 8011	**Acclamation Insurance Mgmt. Services** PO Box 21800 Fresno, CA 92729 209-227-9891

3. **For accidents that result in a fatality or a serious injury** (i.e. loss of a member of the body/amputation, in-patient hospitalization in excess of 24 hours for other than observation, or a serious degree of permanent disfigurement like crushing or severe burns): in addition to steps 1 and 2 above, the supervisor must notify the nearest Cal-OSHA District office within 8 hours. For a list of the Cal-OSHA District offices phone numbers and detailed instructions for reporting serious injuries, please go to the links provided below:

   http://www.dir.ca.gov/asp/DoshZipSearch.html

What if my injured employee is physically unable to fill out the Employee's Report of Injury?
Use common sense and good judgment. If the injury is severe - remember, your employee's health and care are first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident.

What if my employee refuses to fill out or sign an Employee's Report of Injury?
Of course, you cannot make an employee fill out the document. You can however stress the importance of getting their account of the accident to help prevent the injury from happening again. Also, still obtain the supervisor's report as well as any witness statements.


INJURED AT WORK?
AMC Call Connect
CALL THE 24/7 NURSE TRIAGE HOTLINE
1-844-691-4111
IF THIS IS A LIFE THREATENING INJURY OR ILLNESS, CALL 911 IMMEDIATELY.
ALLIED MANAGED CARE INCORPORATED
AMC. Smarter Solutions.

FORM 4B

CLEAR

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY ORILLNESS	Please complete. in triplicate (type, if possible). Mail two copies to: Insurance Carrier's Name: CSJVRMA, MANAGED BY AIMS Address: P.O. Box 269120 City: Sacramento State: Ca Zip:	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 ot obtaining or denying workers' compensation benefits or payments is guilty of a felony.

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 knowledgean amended 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.

EMPLOYER

1. FIRM NAME: CITY OF LINDSAY
1A. POLICY NUMBER: CSJVRMA-LINDSAY
2. MAILING ADDRESS (Number and Street, City, ZIP): P.O. BOX 369
2A. PHONE NUMBER: (559) 562-7102
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.: LOCAL GOVERNMENT
6. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER N/A ☐
9. DATE OF BIRTH N/A ☐
10. HOME ADDRESS (Number and Street, City, ZIP)
110A. PHONE NUMBER
1 1. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title-NO initials, abbreviations or numbers.)
13. DATE OF HIRE
14. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
14A. Under what class code of your policy were wages assigned?
15. GROSS WAGES/SALARY PER $ ☐ HOUR ☐ DAY ☐ WEEK ☐ TWO WEEKS ☐ MONTH ☐ OTHER - SPECIFY _____

INJURY OR ILLNESS

16. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
16A. COUNTY
16B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
17. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
18. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
19. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
20. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tandonitis on left elbow, lead poisoning.
2 1. 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.
22. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
22A. PHONE NUMBER
23. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
24. DATE OF INJURY OR ONSET OF ILLNESS
25. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
26. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
27. IF EMPLOYEE DIED. DATE OF DEATH
28. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
29 DATE LAST WORKED
30. DATE RETURNED TO WORK
31. IF STILL OFF WORK, CHECK THIS BOX ☐
32. PAID FULL DAY'S WAGES FOR DATE OF INJURY? ☐ YES ☐ NO
33. SALARY BEING CONTINUED? ☐ YES ☐ NO
34. 0THER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO
35. DATE OF EMPLOYER'S KNOWLDEGE/NOTICE OF INJURY
36. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM
37. EMPLOYMENT STATUS (permanent, temporary part-time, or seasonal)

PLEASE DO NOT USE THIS COLUMN

CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODEDBY

Completed by (type or print)	Signature	Title	Date

FORM 5020 (REV. 6)
1992

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

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

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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.

Empleado: *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 firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito 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 "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today'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. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* **CITY OF LINDSAY**
11. Address. *Dirección.* **251 E HONOLULU ST, PO BOX 369 LINDSAY CE 93247**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
AIMS - P.O. Box 269120 Sacramento, CA 95826
16. Insurance Policy Number. *El número de la póliza de Seguro.* **CSJVRMA**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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 compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Complete and send with the Employer's First Report to:

ACCLAMATION INSURANCE MANAGEMENT SERVICES
P.O. Box 28100
FRESNO, CA 93729
800-559-9891

WIG 3005 (6-01)

FORM 4D

SUPERVISOR'S ACCIDENT REPORT WORKERS' COMPENSATION CLAIMS

			DATE & TIME RPT'D.
EMPLOYER: CITY OF LINDSAY		LOCATION	LOCATION CODE NO.
A. EMPLOYEE	NAME	JOB TITLE	
	DEPARTMENT	LOST TIME ☐ NO LOST TIME ☐	FIRST AID ☐
B. TIME AND PLACE OF ACCIDENT	DATE / HOUR / DEPARTMENT	IMMEDIATE SUPERVISOR	
	IDENTIFY EXACT LOCATION WHERE ACCIDENT OCCURRED **(BE SPECIFIC)**		
	JOB OR ACTIVITY AT TIME OF ACCIDENT **(BE SPECIFIC)**		

C. WITNESS - LIST OF NAMES AND ADDRESSES

D. DESCRIBE ACCIDENT

E. ACCIDENT CAUSES (EXPLANATION)
UNSAFE CONDITION:

F. UNSAFE ACT

G. CORRECTIVE ACTION TAKEN - INCLUDE BOTH EMPLOYEE AND SUPERVISOR ACTIONS TO PREVENT FUTURE OCCURRENCES:

NAME TITLE PHONE

SIGNATURE DATE

FORM 4E-EMPLOYEE'S REPORT OF INJURY

(To complete by the Supervisor along with the injured employee)

Employee's name:		Gender: M F
Date of birth:____/____/____	Contact telephone #:	
Home address:		
City:	State:	Zip Code:
Present job classification:	Department/Division:	
Date of accident/incident:	Time of accident/incident: _____ a.m. p.m.	
Date reported:	If date reported different from injury date, give reason:	
Location of accident/incident (address and specific area):		
Describe fully how accident/incident occurred (including events that occurred immediately before the accident/incident). Include relevant photos and diagram as necessary:		
Describe injury or illness sustained due to the accident/incident (e.g., strain, sprain, burn, fracture, etc.):		
Body part(s) affected/injured (e.g., head, back, hand, etc.)?		
Name of your supervisor:		Phone #:
Name(s) of witness(es):		Phone #:
Name(s) of witness(es):		Phone #:
When did you report the injury/illness to your supervisor?		
To whom did you report the injury/illness (if other than your supervisor)?		
Do you require medical attention? Yes No Maybe	Have you been treated by a physician for this injury/illness before? Yes No	
What can the City of Lindsay do to help prevent similar accidents/incidents?		
Signature of employee:		Date:

FORM 4F-ACCIDENT WITNESS STATEMENT

(To be completed by Accident Witness)

Name of employee involved in accident/incident:		
Name of witness:		
Home address (witness):		
City:	State:	Zip Code:
Contact telephone #:	Is witness a City employee? Yes No	
If witness is a City employee, Department/Office assigned:		Job title or occupation:
Date of accident/incident:	Time of accident/incident: a.m. p.m.	
Location where the accident/incident occurred (include the address and specific area):		
Describe fully how accident/incident occurred. Include events that occurred immediately before the accident/incident. List all objects and substances involved. Include relevant photos and diagram as necessary.		
Describe bodily injury/illness sustained (be specific about body part(s) affected):		
Recommendation on how to prevent this type of accident/incident from recurring:		
Signature of witness:	Date:	

FORM 4G-CITY OF LINDSAY WORKERS' COMPENSATION BENEFITS

This is to notify you of benefits which are available to you through California's Workers' Compensation system.

Most California workers are protected in the event of job-related injuries and illness by Workers' Compensation Insurance, and in your case by your employer's self-insurance program, which is paid for by your employer. If you are injured or become ill as a result of your job, the City pays for medical care, necessary rehabilitation services, income in case you're disabled and can't work, or death benefits to your dependents.

MEDICAL CARE – All authorized expenses are paid in full, including doctor's fees, medicines, hospital and surgical costs, lab tests, x-rays, wheelchairs, crutches, etc.

REHABILITATION – If your injury or illness prevents you from returning to your same occupation or work, you may be eligible for vocational rehabilitation.

DISABILITY INCOME – If you doctor says you are unable to work, you'll receive tax- free cash payments of two-thirds of your average weekly wage up to a maximum weekly amount set by law. You may be eligible to receive your full salary for up to six months. If you have a permanent disability, you'll receive payments in accordance with a formula set by law.

SELECTION OF DOCTORS – You may be treated by your own doctor for any job- related injury if you notify your employer, in writing, of the name of your personal physician before you are injured. Your "personal physician" means a licensed physician and surgeon who has treated you in the past and who keeps your medical records. Otherwise, your employer will refer you to a local doctor if you need medical care. After 30 days have passed following the date of your injury, you may see a doctor of your choice, but you must give your employer the name and address of that doctor.

QUESTIONS – If you have any questions or need help, ask your employer. Or you may contact the nearest Information and Assistance Officer of the State of California's Division of Industrial Accidents. If you need further assistance, you may contact the Workers' Compensation Appeals Board.

REPORT YOUR INJURY – Always immediately report a work-related injury or illness to your supervisor.

I have read the information supplied to me regarding workers' compensation benefits available to me as an employee of the City of Lindsay.

If I am injured or become ill as a direct result of my job, I elect to receive medical treatment by a local, city appointed physician. ____ Yes _____ No

If I am injured or become ill as a direct result of my job, I elect to receive medical treatment by my own physician. Yes _____ No. _____

Physician Name _____

Physician Address _____

_____

Physician Phone No. _____

_____ _____

Employee Signature Date

FORM 5-NEAR-MISS REPORTING AND INVESTIGATION FORM

Note: A **Near-Miss** is an unplanned event that did not result in an injury and/or illness but had the potential to do so:

Name of the employee completing this form

Supervisor Safety Representative Witness Other If other, please indicate job title:	Contact Phone Number:
Date of the Near-Miss event:	Time of the Near-Miss:_____☐a.m. ☐p.m.
Location where the Near-Miss event occurred: Address: Area:	Why did you get hurt today? What happened?
Supervision at time of accident: ☐ Directly supervised ☐ Indirectly supervised ☐ Not supervised ☐ Supervision not feasible	Employee was working: ☐ Alone ☐With crew or fellow worker ☐Other If other, specify:

Description of the Near-Miss event. Please explain the following: 1) **Who** was involved in the Near-Miss 2) **What** exactly happened **3**) **How** did the Near-Miss occur (include photos and diagram and use additional sheet if necessary)

Were there unsafe acts that contributed to this Near-Miss event? ☐ Yes ☐ No
If "Yes", check all that apply below.

☐ Lack of training or skill
☐ Lack of written procedure
☐ Inadequate procedure
☐ Failure to anticipate
☐ Disabled safety devices
☐ Operating at unsafe speeds
☐ Operating without proper authority
☐ Working on moving equipment
☐ Improper personal protective equipment (PPE)
☐ Failure to lockout
☐ Horseplay
☐ Unsafe lifting
☐ Improper attire
☐ Poor housekeeping
☐ Distracted
☐ Rushed
☐ Failure to use available equipment or tools
☐ Other, specify_____

Were there unsafe conditions that contributed to this Near-Miss event? ☐ Yes ☐ No
If "Yes", check all that apply below.

☐ Inadequate guarding
☐ Unsafe equipment
☐ Defective equipment or tools
☐ Improper lighting
☐ Improper ventilation
☐ Unsafe position/ergonomic issue
☐ Weather conditions - snow and ice
☐ Uneven walking surface
☐ Slippery walking surface
☐ Noise
☐ Other, specify_____

What actions have or will be taken to prevent similar incident/event?

Who is responsible for taking these actions and following up to see that they are complete (Name/Title)?

Expected completion date:	Actual completion date:
Signature:	Date:

	FORM 6-SAFETY AND HEALTH TRAINING FORM

Name of Training:_____ **Date:**_____ **Time: ☐a.m. ☐p.m.**

Training Location:_____ **Group Supervisor:**_____

Trainer Name:_____

Trainer Signature: _____

Employee Name	Employee signature	Job title	Work Location

NOTE: Please attach a copy of the agenda and training materials

APPENDIX A- FACILITY SAFETYINSPECTION

PURPOSE

Facility Inspection. The most widely accepted way to identify hazards in the workplace is to conduct safety and health inspections. You can only be certain that actual situations exist in the workplace if you check them from time to time.

These checklists are not all inclusive. You may wish to add to them or delete portions that do not apply to your workplace. Consider carefully each item as you come to it and then make your decision. Do not spend time with items that have no application to your workplace. Make sure you check each item on the list and leave nothing to memory or chance. Write down what you see (or do not see) and what you think should be done about it. YOU MUST COMPLY WITH THE CALIFORNIA OCCUPATIONAL SAFETY AND HEALTH LAW (CAL-OSHA STANDARDS) FOR MANY OF THE TOPICS COVERED IN THESE CHECKLISTS.

Attached you will find two sample checklist for workshops and office buildings. Each department will be responsible to use/modify the checklist as it applies to their facilities.

Managers have access to the City of Lindsay Risk Control Management Agency provided forms by Sedgwick. Specific facilities inspection checklist can be found at https://riskcontrol.sedgwick.com/Home/tabid/109/Default.aspx

When you have completed the checklists, you will have enough information to decide if problems exist. Once you have identified hazards, you can begin corrective actions and controlprocedures.

SCOPE. The scope of facility inspections should cover the following areas:

- **Processing, Receiving, Shipping and Storage**. Equipment, job planning, layout, heights, floor loads, materials handling and storage methods.
- **Building and Grounds.** Floors, walls, ceilings, exits, stairs, walkways, ramps, platforms, driveways and aisles.
- **Housekeeping Program.** Waste disposal, tools, objects, materials, leakage and spillage, cleaning methods, schedules, work areas, remote areas and storage areas.
- **Electrical.** Equipment, switches, breakers, fuses, switch boxes, junctions, special fixtures, circuits, insulation, extension cords, tools, motors, grounding, compliance with codes.
- **Lighting.** Type, intensity, controls, conditions, diffusion, location, glare and shadow control.
- **Heating and Ventilation.** Type, effectiveness, temperature, humidity, controls, natural and artificial ventilation and exhausting.
- **Machinery.** Points of operation, flywheels, gears, shafts, pulleys, key ways, belts, couplings, sprockets, chains frames, controls, lighting for tools and equipment, brakes, exhausting, feeding, oiling, adjusting, maintenance, lockout, grounding, work space, location and purchasing standards.
- **Personnel.** Training, experience, methods of checking machines before use, clothing, personnel protective equipment, use of guards, tool storage, work practices, method of cleaning, oiling or adjusting machinery.
- **Hand and Power Tools**. Purchasing standards, inspection, storage, repair, types, maintenance, grounding, use and handling.

- **Chemicals.** Storage, handling, transportation, spills, disposal, amounts used, toxicity or other harmful effects, warning signs, supervision, material safety data sheets, supervision, training, personal protective equipment and clothing.

- **Fire Prevention.** Extinguishers, alarms, sprinklers, smoking rules, exits, personnel assignments, separation of flammable materials and dangerous operations, explosive proof fixtures in hazardous locations and waste disposal.

- **Maintenance.** Regularity, effectiveness, training of personnel, materials and equipment used, records maintained, method of locking out machinery and general methods.

- **Personal Protective Equipment**. Type, size, maintenance, repair, storage, assignment of responsibility, purchasing methods, standards observed, training in care and use, rules of use

FORM 7- PHYSICAL HAZARD INSPECTION CHECKLIST-OFFICE BLDG SAMPLE

Facility Name: _____ Inspection Date:_____

Facility Address:

Performed by:

		OK	*Action Needed	N/A
BUILDING EXTERIOR AND PARKING LOT				
Emergency Readiness				
1.	Pathways from exit doors are clear			
2.	Lighting around pathways, stairs and parking lot is adequate. Bulbs in working order			
3.	Fire sprinkler system (water valve open & locked, water pressure, current inspection tag)			
General Work Environment				
4.	Exterior walkways and parking lot in good condition (large cracks, holes, excessive water)			
5.	Building windows/doors in good condition			
6.	Stair handrails in good condition			
7.	Fixed ladders in good condition			
8.	Material stored outside is orderly and out of pathways of equipment and personnel			
OFFICES/LOBBYS/CONFERENCE ROOMS/STORAGE ROOMS/BATHROOMS				
Emergency Readiness				
9.	Emergency exits marked and pathways to exits are clear			
10.	Illuminated exit signs tested monthly			
11.	Fire extinguishers marked, on bracket, easily accessible and inspected monthly			
12.	First Aid supplies stocked per City policy or practice			
13.	Emergency lighting battery tested monthly			
14.	Smoke detectors functioning (battery checked if applicable)			
15.	Door locks operating			
16.	Evacuation maps posted where required			
General Environment				
17.	Walkways are clear of obstructions (debris, cords, wet surface)			
18.	Stair handrails in good condition			
19.	Floors are clean and in good condition (carpet, rugs, and tile)			
20.	Desks, chairs, cabinets, tables and all furniture in good condition			
21.	Shelves and bookcases secure and not overloaded. Storage maintained 24” below ceiling if non-sprinkler or 18” if sprinklers			
22.	Step stools (Type I or II rated) available and in good condition			
23.	Bathrooms in sanitary condition			
24.	AED(s) are inspected/tested on a monthly basis			
Electrical				
25.	Electrical cords and plugs in good condition (no exposed or taped wire)			
26.	Surge protectors in place for computer equipment			
27.	No multi-extension cord usage			
28.	Lighting is adequate. Light bulbs are in working order and fixtures operate properly			
29.	Electrical panels accessible (36”unobstructed access), breakers identified, and all covers in place			
30.	If allowed, portable heaters in good condition (if not permitted, remove from use)			

Hazardous Materials (Chemicals)			
	OK	***Action Needed**	**N/A**
31. Janitor closet is clean and orderly			
32. Safety Data Sheets are available for all hazardous chemicals			
33. Hazardous material containers are labeled with content and hazards			
Machinery/Equipment/Tools			
34. Hand/power tools in good condition (hammer, screw driver, drill, etc.)			
35. Paper cutter in good condition with guard in place			
KITCHEN AREA/BREAK ROOMS			
General Environment			
36. Walkways are clear of obstructions (food, debris, cords, wet surface)			
37. Floors are clean and in good condition (carpet, rugs, and tile)			
38. Chairs, tables, cabinets and all furniture in good condition			
39. Cabinets secure and not overloaded. Storage maintained 24” below ceiling if non-sprinkler or 18” if sprinklers			
Electrical			
40. Electrical cords and plugs in good condition (no exposed or taped wire)			
41. No multi-extension cord usage			
42. Lighting is adequate. Light bulbs are in working order and fixtures operate properly			
Hazardous Materials			
43. Cleaning chemicals are labeled with content and hazards			
Machinery/Equipment/Tools			
44. Kitchen appliances clean and in good condition. No frayed electrical cords			
45. Kitchen knives stored in a knife block or separately from other utensils			
Personal Protective Equipment			
46. Pot holders readily available			

Additional hazards identified during inspection	
48.	
49.	
50.	
51.	
52.	
53.	
54.	
55.	
56.	
57.	

CORRECTIVE ACTION LOG

REF #:	CORRECTIVE ACTION:	ASSIGNED TO:	COMPLETION DATE:

Attach additional sheet if necessary

Corrective Action Reviewed by: _____ **Date:** _____

FORM 8-HAZARD INDENTIFICATION INSPECTION CHECKLIST- WORKSHOP SAMPLE

Location: _____ **Area:** _____

Inspected By: _____ **Date:** _____

This checklist is to be completed annually. Mark potential hazards according to your judgment. Check all items that apply, and make comments where warranted. Place an "X" in the appropriate box to indicate the item is compliant/safe (Yes), non-compliant/hazardous (No), does not apply to the area (NA). Send a copy of this checklist to _____ and retain the original for one year. Document corrective action taken and date of completion - Use the bottom of the second page or attach additional sheets as needed.

	Yes	No	N/A	Corrective Action/Date Completed
Required Postings – Posted on bulletin boards or other appropriate locations.				
1 Up-to-date Labor and Industry workplace posters are displayed (i.e. Safety & Health Protection on the Job, Emergency Telephone Numbers, Workers' Comp Notice to Employees, etc.)				
2 Safety Data Sheet (SDS) Information available				
3 Cal/OSHA Powered Industrial Truck Guidelines posters are displayed in the break room adjacent to the vehicles' use area and adjacent to the vehicles' storage				
4 NFPA Hazardous Materials Diamond signs are posted on the exterior of the building where hazardous materials are used or stored, and the signs display the appropriate hazard ratings				
General Work Environment & Housekeeping				
5 Areas are clean, free of clutter, and provide ample working space				
6 Shelving and storage cabinets are secured to prevent tipping				
7 Stored materials are orderly, do not overload the shelves, and do not extend beyond the shelving				
8 Stairways are in good repair and landings are free of stored materials				
9 Walking surfaces are in good repair and free from trip/fall hazards				
10 Walking surfaces are free of wet or oily conditions				
11 Workshops are free of apparent hazards and safety concerns				
Emergency Response and Life Safety				
12 Emergency evacuation procedures and routes are posted				
13 Exit doors are free of inappropriate locking devices				
14 Exits and walkways are unobstructed				

15	Exits are clearly posted or otherwise identified				
16	Eyewash/shower stations are accessible, operational & properly maintained				
17	Fire extinguishers are mounted, accessible, fully-charged & serviced within the last 12-months				
18	First aid kits are adequately stocked & contain only first aid supplies				
19	Sawdust collection system is emptied and inspected regularly				
Personal Protective Equipment (PPE)					
20	Employees are wearing appropriate PPE for tasks being completed (gloves, clothing, face shield, etc)				
21	Eye protection is available (glasses, goggles) & worn when needed				
22	Hearing protection is provided (ear plugs, ear muffs) & worn appropriately when needed				
23	Signs warning employees to wear PPE are posted				
Hazardous Materials (Raw & Waste)					
24	Primary & secondary chemical containers are labeled to identify the contents & specific hazard				
25	Flammable & combustible materials are stored in NFPA-approved containers/cabinets				
26	Spill containment is provided for stored hazardous & industrial materials				
27	Spill response kits are available in hazardous & industrial material storage areas				
28	No noticeable leaks or spills are present				
29	Waste containers are closed & properly labeled regarding waste & accumulation dates				
30	Work areas where chemicals are present are free of open beverages & food				
Electrical					
31	A 36-inch clearance is maintained in front of all electrical panels				
32	Electrical cords and plugs are in good condition (not frayed or taped)				
33	Wallplates are in place over outlets and switches				
Tools & Equipment					
34	All guards are in place to prevent contact with point of operation or in-running nip point				
35	Grinding wheel guards are in place & adjusted properly (tool/work rest 1/8 inch, tongue guard 1/4 inch; flanges in place and properly adjusted)				
36	Only Type I & Type II rated ladders are utilized & labels are in place				

36	Tools & equipment are in good condition				
37	Operating permits for all air compressors are current & posted				
Welding Operations					
38	Compressed gas cylinders are secured in an upright position with chains or straps				
39	Welding ventilation systems are operations, clean & filters regularly changed				
40	Welding curtains are available & used when appropriate				
Fueling Area					
41	Emergency shut-off switches are labeled and accessible				
42	The permit to pump fuel is displayed at the pumps or in the office				
Other					
43					
44					
45					