FILING INJURY/ILLNESS AND RETURN TO WORK FORMS FOR SANTA CRUZ COUNTY VOLUNTEER FIREFIGHTERS

Once the supervisor learns of Volunteer injury/illness and the Volunteer needs medical attention or loses time from work, the following forms must be completed:

- ❑ **PROVIDENT A-31369** *(First Notice of Claim Form)*
  1. **Volunteer** must complete, sign and submit form.
  2. **Battalion Chief** must review and sign.
  3. ***Fax Immediately*** to the Training Battalion 831-335-2068
  4. ***Mail a hard copy*** to the Training Battalion; 1 copy for Worker's Compensation;
  5. ***Original*** to Provident

- ❑ **SUPERVISOR'S REPORT OF EMPLOYEE INJURY**
  1. **Supervisor** must complete, sign and submit form.

- ❑ **FORM 5020 (***State of California Employer's Report of Occupational Injury or Illness)*
  2. **Supervisor, not Volunteer**, must complete, sign and submit form.
  3. **Battalion Chief** must review and sign.
  4. ***Fax Immediately*** to the Training Battalion 831-335-2068
  5. ***Mail a hard copy*** to the Training Battalion

- □ **SCIF 3301/DWC FORM 1** *(State of California Employee's Claim for Workers' Compensations Benefits)*
  1. **Volunteer** must complete, sign and submit form.
  2. **Battalion Chief** must review, complete and sign. Give A copy to Volunteer.
  3. ***Fax Immediately*** to the Training Battalion 831-335-2068
  4. ***Mail a hard copy*** to the Training Battalion

- □ **DWC-1 DECLINATION FORM**
  1. **Supervisor and Volunteer** must complete, sign, and submit form if Volunteer refuses a copy of the DWC 1 form.

- □ **ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE CLAIM FORM**
  1. Supervisor and Volunteer must complete, sign and submit form if Volunteer accepts a copy of the DWC 1 form.

- ❑ **CDF 200** *(Medical Treatment Return to Work)*

- ❑ **CDF/COUNTY FIRE PHYSICAL AND MENTAL STRESS JOB DESCRIPTION**

Supervisor gives Volunteer:

1. CDF 200 Medical Treatment/Return to Work
2. Physical and Mental Stress Job Description

Volunteer gives Physician:

1. CDF 200 Medical Treatment/Return to Work.
2. Physical and Mental Stress Job Description
3. Physician identifies work status and/or restrictions.
4. **Physician MUST sign and date both forms**
5. Have the Physician indicate ***"Workers Compensation"*** on any prescriptions given.

Volunteer then gives the Battalion Chief the following forms, signed by Physician.

1. CDF 200 Medical Treatment/Return to Work.
2. Duty Statement/CDF Physical/Mental Stress Job Description.

AND

Volunteer immediately faxes both forms to the Training Battalion at: 831-335-2068

June 2015

AFTER EACH DOCTORS VISIT

The Volunteer must **immediately fax and then mail hard copies** of the **CDF 200** to the Training Battalion.

**This process continues until the physician either releases the Volunteer to Full Duty or declares the Volunteer unable to return to work in any capacity.*

☐ **You MUST stay in contact with:**

1. **Training Battalion Chief and Coordinator**
    a. **Phone: 831-335-6745**
    b. **FAX: 831-335-2068**
    c. **Address: P.O. Drawer F-2, Felton, CA 95018**
2. **Battalion Chief**
3. **Company Officer/CDF Liaison.**

PROVIDENT
Insuring America's Heroes Since 1928

Important Notice Regarding Fraud

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ***For residents of Maine, Tennessee, Virginia and Washington:***
  It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Print Form Reset Form

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
CLAIMS DEPT FAX: 412-963-0148
www.providentbenefits.com

BOTH SECTIONS MUST BE COMPLETED

Name		Date of Birth / /	Social Security Number
Address	City State Zip Code		Home Phone Number ( )
Email Address			Cell Phone Number ( )
What is your regular, full time occupation?		Employed By (Name of Company)	
Employer's Address	City State Zip Code		Employer's Phone Number ( )
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).		Wages/Earnings Hourly: Weekly:	Date of Hire (Full Time Occupation) / /
Time of Accident ☐ AM ☐ PM	Date of Accident / /	Place of Accident	Date Last Worked / /
What is your injury or illness?		How did it happen?	
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? ☐ Yes ☐ No ☐ Unknown at this time		Did you file with Workers' Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /			
I was partially disabled from / / to / /			
Date you have or are expected to return to work / /			

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

☐ Yes ☐ No – Claimant was a member of your organization at the time of injury or illness ☐ Yes ☐ No – Claimant was engaged in an authorized activity at the time of injury or illness		Policy Number
Name of Fire/Rescue/Ambulance Company/District or Relief Association	Your Municipality	
Print Name and Title	Signed	Date / /
Address City State Zip Code		Telephone Number ( )
Is the claimant a ☐ Volunteer ☐ Career ☐ PT employee ☐ Auxiliary ☐ Other		

See Fraud Warning Important Notice sheet attached.

Print Form Reset Form

Print Form Reset Form

PROVIDENT
Insuring America's Heroes Since 1928

Provident Agency, Inc. - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800-447-0360 Fax: 412-963-0148

NOTE: This authorization allows the _____ to release all information pertaining to an injury that occurred on or about _____ to Provident Agency, Inc. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits including Social Security benefits, to disclose any and all of this information to persons who administer claims for Provident. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Provident obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Provident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above. I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____
(Claimant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Print Form Reset Form

PROVIDENT

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
Provident Agency, Inc.; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963-0148

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

I authorize _____ to release infromation from the record of:
Name of Facility/Person

_____ / / _____ _____ to
Patient Name | Birth Date | SS # / MR #

Provident Agency, Inc. | (412) 963-1200 | (412) 963-0148
Name of Facility/Person | Phone | Fax

272 Alpha Drive, PO Box 11588, Pittsburgh, PA 15238
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): Insurance Benefits

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):
☐ Inpatient ☐ Emergency Department Dates: _____ to _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☑ Mental Health Information ☑ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

☑ Consults	☑ Medical History & Physical Exam	☐ Physican Orders
☑ Discharge Summary/Instructions	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☑ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Reports	☐ Pathology Report	☑ Radiology Report
☑ Emergency Dept. Reports	☑ EKG Report (s)	

☐ Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authrorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the orginal. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature _____ Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature _____ Signature of Authorized Representative ☐ N/A

☐ Parent or Legal Guardian ☐ Power of Attorney
☐ Next of Kin of Deceased ☐ Executor of Estate

Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date _____ Witness # 1 _____ Date _____ Witness # 2 _____

SUPERVISOR'S REPORT OF EMPLOYEE INJURY

Name of Injured:

Date of Birth: **Job Title:**

Date of Injury: **Time:** **AM PM**

Date Reported: **Time:** **AM PM**

Accident Location:

Nature of Injury:

Name of Medical Facility:

Did injured Leave Work?: **Date** **Time** **AM PM**

Did Injured Return to Work?: **Date** **Time** **AM PM**

Describe How Accident Occurred:

Names of Witnesses:

What Steps Have Been Taken to Prevent Similar Accident?:

Supervisor's Signature: **Date:**

Employer:

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
York Risk Services Group, Inc.
P.O. Box 619058 Roseville, CA 95661 FAX: (916) 783-0335 Phone: (800) 422-7244

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or 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: Santa Cruz County Fire Agencies
1a. Policy Number:
2. MAILING ADDRESS: (Number, Street, City, Zip): P.O. Drawer F-2 Felton, CA 95018
2a. Phone Number: (831) 335-6745
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 6059 Highway 9 Felton, CA 95018
3a. Location Code:
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Fire Suppression and Reforestation
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☑ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED: _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK: _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, 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
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

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. Attached is the form for filing 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 required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to 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 has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

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.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. 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.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

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. Se adjunta el formulario 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 se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar 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 ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

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 se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

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. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

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

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your 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) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

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 web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. 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 pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

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

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo 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.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov**.**

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, ó consulte con la pagína Web en **www.californiaspecialist.org**.

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 as the cover sheet of this form.

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

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. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

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

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.

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

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

9. Name of employer. *Nombre del empleador.* Santa Cruz County Fire Agencies
10. Address. *Dirección.* 6059 Highway 9, Felton, CA 95018
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    York Risk Services Group, Inc. P.O. Box 619079, Roseville,CA 95661-9079
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su 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*

6/10 Rev.

Santa Cruz County Fire Agencies
Insurance Group

RECEIPT

RECEIPT OF WORKER'S COMPENSATION CLAIM FORM (DWC-1)

Supervisor and employee complete this form IF employee declines to complete/file DWC-1 Form
Ensure that the employee retains the DWC-1 Form

Employee's Name (print) _____

Fire District _____

Injury Occurred **Date:** _____ **Time:** _____

Nature of Injury _____

Place Injury Occurred _____

Employee Reported Injury **Date:** _____ **Time:** _____

Claim Form (DWC-1) Offered to Employee **Date:** _____ **Time:** _____

Employee's Signature _____

Supervisor Completing Form (print) **Name:** _____

Date: _____ **Time:** _____

ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE CLAIM FORM

I acknowledge receipt of an **Employee's Claim for Workers' Compensation Benefits**

(Form DWC-1 from_____

Manager, Supervisor, or Lead Person

on_____ at _____

Date Time

_____ _____

Employer Signature of Employee

STATE OF CALIFORNIA
DEPARTMENT OF FORESTRY & FIRE PROTECTION

MEDICAL TREATMENT/RETURN TO WORK

CAL FIRE-200 (Rev. 12-07)

Reset Form Print Form

MEDICAL TREATMENT/RETURN TO WORK (CAL FIRE-200)

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

TO: SUPERVISOR, INJURED WORKER, AND ATTENDING DOCTOR

Provide this form and attachments to the doctor. The signed original is to be returned and maintained by the Return-to-Work Coordinator (Industrial) or Administrative Unit (Non-Industrial). If the injury is work-related, attach this form to the Employee's Claim for Workers' Compensation Benefits (SCIF-3301) and the Employer's Report of Occupational Injury or Illness (CAL FIRE-3067 or CAL FIRE-3579). If the injury is not work-related, and if applicable, attach this form to the first claim for Non-industrial Disability Insurance (DE-8501). Attach the workers' Essential Functions Duty Statement and, if applicable, the CAL FIRE Physical/Mental Stress Job Description to this form. This form is to be completed and sent to the Supervisor and/or Return-To-Work Coordinator upon **EACH** visit that the injured worker has with the doctor/medical provider.

NAME OF INJURED/ILL EMPLOYEE	CLASSIFICATION OR INMATE/WARD#	DATE OF INJURY
NAME OF EMPLOYER/INSTITUTION --		PHONE # --
ADDRESS CITY, STATE ZIP CODE --		
SUPERVISOR'S NAME	SUPERVISOR'S CLASSIFICATION	PHONE

INJURY STATUS REPORT

TO: ATTENDING DOCTOR/MEDICAL PROVIDER **DATE OF TREATMENT:** _____

Check the boxes below that apply. A short-term, modified work assignment may be available. Direct any questions on modified work assignments to the employee's supervisor. Return this form to the employee or the authorized person that accompanied him or her.

This confirms the above individual received medical treatment for an injury or illness that is: (check one)

☐ Non-work-related ☐ Work-related ☐ May be work-related ☐ Unknown

I have considered the following in determining the injured worker's ability to perform his or her work duties as stated within the injured worker's: ☐ Essential Functions Duties Statement (PO 199) ☐ CAL FIRE Physical/Mental Stress Job Description (safety classes)

TREATMENT ADMINISTERED	WORK STATUS	PHYSICAL/MENTAL LIMITATIONS
☐ Office visit/initial injury treatment ☐ Re-evaluation ☐ Redress ☐ Medication ☐ Physical therapy ☐ Physical exam ☐ Referred/follow-up treatment/exam on: _____ by: _____ ☐ Telephone advice: _____ ☐ Other: _____ ☐ Assistive devices: _____ ☐ Explanatory information attached	☐ Return without restrictions on: _____ ☐ Return to Modified work on: _____ (Attach detailed modifications.) ☐ Unable to work until: _____ ☐ Never able to return to assigned work from: _____ (Attach explanation) ☐ Medication effects on performance: _____ _____	☐ No prolonged or ☐ No: ☐ Standing ☐ Walking ☐ Climbing ☐ Bending ☐ Sitting ☐ Stooping ☐ Limited use of hands: ☐ Left ☐ Right ☐ Work near machinery: ☐ No ☐ Modified ☐ Twisting motion: ☐ No ☐ Modified ☐ Weight lifting restriction/duration: Restriction: _____ pounds Duration: ☐ 1-33%--Occasional ☐ 34-66%--Frequent ☐ 67-100%--Constant Date(s) limitations apply: From: _____ To: _____

As of this date, the undersigned certifies that the information contained in this document is true and accurate to the best of his/her knowledge and is in compliance with Labor Code Section 139.3.

DOCTOR/MEDICAL PROVIDER		PHONE ( ) FAX ( )
ADDRESS	CITY	STATE ZIP CODE
SIGNATURE		DATE

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE COMMENTS: NEXT APPOINTMENT DATE: _____

EMPLOYEE SIGNATURE: _____ DATE SIGNED: _____

CAL FIRE/COUNTY FIRE PHYSICAL AND MENTAL STRESS JOB DESCRIPTION

VOLUNTEER FIREFIGHTER

A DESCRIPTION IS GIVEN BELOW OF THE PHYSICAL AND MENTAL STRESSES TO WHICH A VOLUNTEER FIREFIGHTER IS SUBJECTED TO AT CAL FIRE/COUNTY FIRE. YOUR JUDGMENT IS NEEDED AS TO THE APPLICANT'S CAPACITY TO PERFORM THE REQUIRED DUTIES. IN YOUR CONCLUSION, TAKE INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE AND THE APPLICANT'S ABILITY TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.

The Volunteer Firefighter is a member of a fire crew and works under close supervision of a Fire Apparatus Engineer, Fire Captain or Battalion Chief to perform the full range of firefighting duties in suppression of vehicle, building and vegetation fires.

Specifically, the Volunteer Firefighter responds to alarms as a member of a fire crew on such fire apparatus as engines, water tenders and squad/rescue vehicles; connects, lays, and operates hose lines; enters burning areas and structures with charged hose lines; uses hand tools and fire equipment to contain and suppress fire. The individual, as a crew member of a rescue unit, assists in Emergency Medical Service, response rescue, and salvage operations. Also assists in performing fire prevention inspections; assists in equipment maintenance and repair; inspects, cleans and repairs fire hose and equipment, sharpens fire tools; may operate motor vehicles in emergency and non-emergency situations; may assist in the training of other fire personnel.

The Volunteer Firefighter must have the ability to read and write English at a level for successful job performance; learn to operate fire apparatus and special fire suppression equipment efficiently and safely; do heavy physical work; follow oral and written directions; write legibly; exercise good judgment in hazardous fire suppression activity; analyze situations accurately and take effective action; work compatibly with others, and be able to work in situations where heat is intense; in addition, to tolerate heavy smoke, dust and exposure environments.

The individual must possess: visual acuity (Snellen) of not less than 20/100 without correction in each eye corrected to not less than 20/30 in one eye; color vision sufficient to discriminate between electrical cable and pipe color coding, and color vision sufficient to correctly identify vehicle colors; hearing adequacy within speech frequency (uncorrected); normal use of both hands and both feet; physical strength and agility; weight in proportion to height; no more than mildly susceptible to poison oak.

CATEGORY I - ARDUOUS PHYSICAL WORK

Duties involve field work requiring physical performance calling for above-average ability, endurance, and superior condition, including occasional demand for extraordinarily strenuous activities in emergencies, under adverse environmental conditions and over extended periods of time; requires running, walking, difficult climbing, jumping, twisting, bending and lifting over 25 pounds; and the pace of work is typically set by the emergency situation.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE CAL FIRE/COUNTY FIRE PHYSICAL/MENTAL STRESS JOB DESCRIPTION FOR THE EMPLOYEE NAMED BELOW AND THAT IN HIS/HER JUDGMENT THE EMPLOYEE HAS THE CAPACITY TO PERFORM THE REQUIRED DUTIES, HAS TAKEN INTO ACCOUNT THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE, AND THE EMPLOYEE IS ABLE TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION.

EMPLOYEE NAME (PRINT)	**WORK UNIT**
MEDICAL PROVIDER'S NAME (PRINT)	**DATE**
MEDICAL PROVIDER'S SIGNATURE	
ADDRESS (PRINT)	
TELEPHONE	

Santa Cruz County Fire Department

Physical and Mental Stress Statement
EMR (Emergency Medical Responder)

A description of the physical and mental stresses a volunteer EMR (Emergency Medical Responder) may be subjected is given below. Your judgment as to the volunteer's capacity to perform the required job duties is needed. In your conclusion, take into account the long range outlook for continued performance and the employee's ability to safely perform these duties without significant increased risk of injury to self or others due to medical condition.

The support and EMS responder is assigned to either an urban or rural area and must have endurance to respond and perform a variety of duties including: prevention and education programs, fundraising activities, company administrative assignments, station maintenance, assist with structure fire rehab, structure fire incident accountability and traffic control. In addition, the EMS responder will also respond to medical aid calls and perform CPR as needed.

The support and EMS responder must have hearing adequacy within speech frequencies (uncorrected), full use of hands and feet, the necessary strength and agility required for extensive bending, stooping and squatting. He or she must be able to move objects up to 50 pound.

Duties involve field work requiring physical performances involving average ability.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE CAL FIRE/COUNTY FIRE PHYSICAL/MENTAL STRESS JOB DESCRIPTION FOR THE EMPLOYEE NAMED BELOW AND THAT IN HIS/HER JUDGMENT THE EMPLOYEE'S CAPACITY TO PERFORM THE REQUIRED DUTIES, HAS BEEN TAKEN INTO ACCOUNT FOR THE LONG-RANGE OUTLOOK FOR CONTINUED PERFORMANCE, AND THE EMPLOYEE'S STATUS TO SAFELY PERFORM THESE DUTIES WITHOUT SIGNIFICANT INCREASED RISK OF INJURY TO SELF OR OTHERS BECAUSE OF MEDICAL CONDITION HAS BEEN DESIGNATED.

EMPLOYEE NAME (PRINT)		**VOLUNTEER COMPANY**
PHYSICIAN'S RECOMMENDATIONS:	☐ **DO NOT RELEASE TO FULL DUTY**	**DATE**
	☐ **RELEASE TO FULL DUTY**	**DATE**
MEDICAL PROVIDER'S NAME (PRINT)		
MEDICAL PROVIDER'S SIGNATURE		
ADDRESS (PRINT)		
TELEPHONE		