Omaha National Claims Kit

Effective Date: _____

Policy Number: _____

Facility Name: _____

Facility Address: _____

Work Comp. Coordinator: _____

W.C. Coordinator Phone: _____

W.C. Coordinator Email: _____

Report Claims:
Claims@OmahaNational.com
ph. 844-761-8400 | f. 844-761-8402

Provider Search:
MPN.OmahaNational.com
MPN@OmahaNational.com

Omaha National Customer Service
844-761-8400

Mailing Address:
Omaha National Claims
PO Box 451139
Omaha, NE, 68145

Presented By

Shomer Insurance Services, LLC,
an Alera Group Company
5805 Sepulveda Boulevard, #500
Sherman Oaks, CA, 91411
License Number 0M81972
ph. 323-934-8160 | f. 323-934-8170

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Workers' Compensation Coordinator Duties

As the Work Comp Coordinator, you have the following responsibilities:

- Primary contact for workers' compensation program.
- Know which occupational clinics and emergency rooms treat your employees - during normal business hours and after hours.
- Authorize medical treatment and notify administrator of incident.
- Gather and review incident reports from employee and supervisor.
- Submit claim forms to insurance company (and cc Management Company when appropriate).
    - Report claim as soon as possible. Preferably within 24 hours after incident or date of knowledge.
- Coordinate medical care.
    - Develop relationship with occupational clinic.
    - Send work status reports to carrier. *Never assume the clinic is sending reports to carrier.*
    - Diary follow up visits and stay in touch with injured employer.
    - Coordinate temporary modified duty
    - Report to examiner if employee is missing medical appointments.
- Coordinate modified duty with various departments. Document offer of modified duty and copy insurance company. Work with HR to complete interactive process.
- Send all work comp documents to insurance company.
    - Examples – Modified Duty Offer Letter, Medical Reports, Bills, Letters of Representation, Subpoenas and Hearing notices.
- Be ready to send wage statements and/or personal files if needed. Know your sources to gather those documents.
- Ensure there is a trained employee to report claims when the work comp coordinator is not present.
- Have claim kits printed and ready at designated spot.
- Relay any concerns or new information to claim examiners
    - Examples – employee has second job, injury happened outside of work, employee was written up recently, injured reported only after employee was denied PTO, or other suspicious behavior.
- Be the main contact at the facility should the claim examiner need additional information about employee and/or incident.
- Keep track of open and closed claims.
- Participate in periodic risk management conference calls to discuss incidents and work status.

I understand and accept my role as Work Comp Coordinator. If I have any questions, I will contact my Shomer Risk Manager

_____	_____	_____
Signature	Name/Title	Date

Work Comp Incident Checklist
If the employee **refuses** medical treatment:

Employee Name:_____ Date of Incident:_____

Facility:_____ WC Coordinator:_____

Dept. Supervisor: _____

Offer medical care upon first knowledge of a job-related incident. Call 911 for emergencies.

Employee Responsibility:

- ☐ Sign Refusal of Medical Treatment same day of the incident.
- ☐ Complete Employee's Report of Workplace Incident same day of the incident

Department Supervisor Responsibility:

- ☐ Complete Supervisor's Incident Investigation Report within 24 hours of the incident.
- ☐ Implement corrective action, safety re-training, or 1-on-1 coaching.

Work Comp. Coordinator Responsibility:

- ☐ Collect all forms and file in employee's file.
- ☐ Share investigative findings with safety coordinator and administrator
- ☐ Periodically check in with employee regarding their well-being. Send to occupational clinic if their condition changes or the employee changes their mind.

Do not report this incident. STOP HERE – no additional incident forms are needed.

Regardless of extent of treatment, administrator must review incident report and implement corrective action.

Work Comp Incident Checklist
If the employee **seeks** medical treatment:

Employee Name:_____ Date of Incident:_____

Facility:_____ WC Coordinator:_____

Dept. Supervisor: _____

Offer medical care upon first knowledge of a job-related incident. Call 911 for emergencies.

Employee Responsibility:

- ☐ Complete Employee's Report of Workplace Incident same day of the incident.
- ☐ Seek treatment at occupational clinic/preferred doctor.
- ☐ Attend regular appointments until discharged from care.

Department Supervisor Responsibility:

- ☐ Complete Supervisor's Incident Investigation Report within 24 hours of the incident.
- ☐ Implement corrective action, safety re-training, or 1-on-1 coaching.
- ☐ Assist Work Comp. Coordinator locate the appropriate modified duty.
- ☐ Follow-up with employee regarding their well-being and escalate any complaints to administrator.

Work Comp. Coordinator Responsibility:

- ☐ Call occupational clinic to authorize treatment, provide employee's name, describe incident and any concerns, and remind clinic modified duty is available.
- ☐ Send employee to clinic and instruct them to return with doctor's work status report.
- ☐ Collect incident reports from supervisor and employee.
- ☐ Email completed claim form, Employee Incident Report, Supervisor's Incident Report, and doctor's work status - refer to cover page of claim kit or contact RM@shomerinsurance.com for help.

If the claim seems suspicious, note in your claim, "Investigate."
Alert your claim examiner and Shomer Risk Manager.

- ☐ After each medical visit:
  - Follow modified duty restrictions until employee returns to full duty. Always offer mod. duty in writing.
  - Diary follow-up appointments and request work status report after each visit. If employee misses appointment, ask claim examiner to reschedule.
  - Email work status reports, authorization requests, and discharge papers to claim examiner. Never assume a doctor's office is providing information to the carrier.
  - If you are unable to accommodate restrictions, notify claim examiner and human resources.
  - Once employee is discharged from care, email claim examiner and close your file.
- ☐ Share investigative findings with safety coordinator and administrator.

Regardless of extent of treatment, administrator must review incident report and implement corrective action.

Employee Refusal of Medical Treatment Form

I have been advised by my Manager/Supervisor that I may seek medical treatment for the injury that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my Manager/Supervisor immediately should the need arise.

Employee:

Employee Printed Name _____

Date and Time of Injury per Employee _____

List specific body parts _____

List specific injury type _____

Employee's Signature _____

Today's Date _____

Supervisor:

Supervisor Signature _____

Today's Date _____

Manager/Supervisor Comments:

_____

_____

_____

_____

Manager/Supervisor Note: Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious, get medical attention and/or call 9-1-1, if necessary. Retain this document in employee's file.

Forma Para El Empleado de Denegación de Tratamiento Medical

Mi director/superintendente me ha avisado que yo puedo buscar tratamiento medical para el daño que me ocurrió en el trabajo, por la información enciendo abajo. Yo pienso que tratamiento medical, no el necesario a este tiempo. Yo le informo a mi Director/Superintendente inmediatamente, si llega la necesidad de tratamiento.

Empleado:

Nombre del Empleado-Imprimado _____

Fecha y hora del daño _____

Lista des partes,
especificas, del cuerpo _____

Lista del tipo de daño, especifico. _____

Firma de empleado _____

Fecha de hoy _____

Supervisor:

Supervisor Signature _____

Today's Date _____

Manager/Supervisor
Comments

_____

_____

_____

Manager/Supervisor Note: Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious get medical attention and/or call 9-1-1, if necessary. Retain this document in employee's file.

Employee's Report of Workplace Incident

Instructions: Use this form to report **all** work related incidents - no matter how minor. Complete form within 24-hours and give to their supervisor.

I am reporting a work related: ☐ Injury ☐ Illness ☐ Incident with no medical attention required

Your Name:	Job Title:
Supervisor's Name:	Have you reported this incident to your supervisor? ☐ Yes ☐ No
Date of Incident:	Time of Incident:
Name of Witness (if any):	Where in the facility did it happen? (Include room number)
What were you doing at the time?	Circle area injured:
Describe step-by-step what led up to the incident and include type of equipment used (gait belt, mechanical lift, etc.):	
What could have been done to prevent this incident?	What parts of your body were injured?
	Has this part of your body been injured before? ☐ Yes ☐ No If yes, when?

Your signature: _____ (sign) _____ (date)

Reviewed by:	Date:

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Incidente del Lugar de Trabajo de Empleado

Instrucciones: Utilice este formulario para informar **todos** los incidents relacionado con el trabajo – no importa que tan pequeño. Complete el formulario dentro de las 24 horas y entrégueselo a su supervisor.

Estoy reportando (circle uno): ☐ Lesión ☐ Enfermedad ☐ Se require incidente sin attención médica

Su Nombre:	Titulo Profesional:
Nombre del Supervisor:	¿Ha informado este incidente a su supervisor? ☐ Si ☐ No
Fecha del Incidente:	Hora del Incidente:
Nombre de los testigos (si los hay):	¿En qué parte de la instalación suicedió? (Incluya el número de habitación.)
¿Qué estabas hacienda en ese momento?	Área del círculo lesionada: (Circule la área)
Describa paso por paso lo que provocó el incidente e incluya el tipo de equipo utilizado (banda para caminar, levantamiento mecánico, etc.):	
¿Qué se podría haber hecho para evitar este incidente?	¿Qué partes de tu cuerpo se lesionaron?
	¿Esta parte de tu cuerpo ha sido herida antes? ☐ Si ☐ No ¿Esta parte de tu cuerpo ha sido herida antes?

Su firma: _____ (firmar) _____ (fecha)

Revisado por:	Fecha:

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Medical Authorization Form: Workers' Compensation

This form should be completed by department head/supervisor or on-duty nurse and given to injured employee to take to the designated clinic for the first visit.

Injury Information

Employee name:	
Date of injury:	
Details:	

Facility Information

Facility name:	
Address:	
Insurance company/claim administrator:	Omaha National Claims, PO Box 451139, Omaha, NE, 68145 ph. 844-761-8400
Policy number:	

Authorized Facility Contact

Referred by:	
Title:	
Phone:	
Date of referral:	

MPN/Medical Provider Information

Clinic name:	
Address:	
Phone:	
Special instructions:	

Fax or Email Work Status Report to: _____

Supervisor Incident Investigation Report

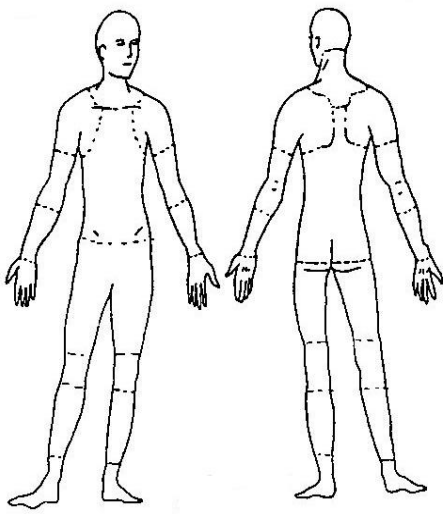
Instructions: Complete this form within 24-hours after an incident or accident. Include as much information as is available at time of investigation. You may need to follow-up on missing information but do not delay the start of

Date of Incident:	This report is made by: ☐ Supervisor ☐ Team ☐ Other _____

Step 1: Employee Information & Type of Injury/Illness

Employee Name:	Sex: ☐ Male ☐ Female	Age:
Name of facility & department:	Job title at time of incident:	

Part of body affected: (shade all that apply)



Nature of Injury:

- ☐ Abrasion/scrape
- ☐ Amputation
- ☐ Bruise
- ☐ Burn
- ☐ Chemical exposure
- ☐ Concussion
- ☐ Crushed
- ☐ Cut/laceration
- ☐ Dermatitis
- ☐ Foreign object
- ☐ Fracture
- ☐ Hernia
- ☐ Human bite
- ☐ Illness _____
- ☐ Poisoning
- ☐ Puncture or Needle stick (circle)
- ☐ Sprain or Strain (circle)
- ☐ Other _____

This employee works:

- ☐ Regular full time
- ☐ Regular part time
- ☐ Seasonal
- ☐ Temporary

Months with this employer:

Months doing this job:

Step 2: Describe the Incident

Exact location in facility where employee was injured:	Exact time:

Incident occurred:

- ☐ Entering or leaving work
- ☐ Doing normal work activities
- ☐ During meal period
- ☐ During break
- ☐ Working overtime
- ☐ Other _____

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Supervisor Incident/Accident Investigation Report

Number of attachments:	Written Witness Statements:	Photographs:	Maps/Drawings:

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include location of incident/accident and names of any machines, objects tools, materials, chemicals, teype of clothing/shoes, protective equipment and other important details.

Description continued on attached sheets: ☐

Step 3: Why did the incident happen?

Unsafe workplace **conditions**: (Check all that apply)

- ☐ Inadequate guard
- ☐ Poor housekeeping or blocked aisles
- ☐ Defective safety device
- ☐ Defective tool or equipment
- ☐ Workstation layout
- ☐ Lighting
- ☐ Ventilation
- ☐ Lack of personal protective equipment
- ☐ Lack of appropriate equipment / tools
- ☐ Unsafe clothing
- ☐ No training or insufficient training
- ☐ Combative patient
- ☐ Other: _____

Unsafe acts by **people**: (Check all that apply)

- ☐ Operating without permission/training
- ☐ Servicing equipment that has power to it
- ☐ Making a safety device inoperative
- ☐ Using defective equipment
- ☐ Using equipment in an unapproved way
- ☐ Unsafe lifting
- ☐ Taking an unsafe position or posture
- ☐ Distraction, teasing, horseplay
- ☐ Failure to wear personal protective equipment
- ☐ Failure to use the available equipment / tools (e.g. Hoyer lift)
- ☐ Failure to use team transfer of patient
- ☐ Other: _____

Why did the unsafe **conditions** exist?

Why did the unsafe **act** occur?

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Supervisor Incident/Accident Investigation Report

Are there incentives to take short-cuts or work faster that may have encouraged the unsage conditions or acts?

☐ Yes ☐ No

If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

☐ Stop this activity ☐ Guard the hazard ☐ Train the employee(s) ☐ Train the supervisor(s)

☐ Redesign task ☐ Redesign work station ☐ Write a new policy/rule ☐ Enforce existing policy

☐ Routinely inspect for the hazard ☐ Personal Protective Equipment ☐ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: ☐

Step 5: Who completed and reviewed this form? (Please Print)

Completed by:	Title:
Department:	Date:

Names of investigation team members (if applicable):

Reviewed by:	Title:
	Date:

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Incident/Accident Witness Report

To be completed by a witness such as: a client or coworker

Witness Information

Witness Name _____

Street Address _____

City, State, Zip Code _____

Phone _____

Fax | Email _____

Insured's Employee Information

Employee's Name | Job Title _____

Date of Incident _____

Time of incident _____

Description of Incident

Please use as many details as possible. Include location, type of equipment in use, clothing/shoes, condition of the floors, weather, where you were in respect to the incident. Attach further pages as necessary:

_____

_____

_____

_____

_____

Signature Date

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Informe de Testigos

Para ser completado por un testigo como: cliente, compañero de trabajo

Información de Testigos

Nombre del Testigo _____

Dirección: Ciudad, Calle, Código Postal _____

Teléfono _____

Fax | Correo Electrónico _____

Información del Empleado del Asegurado

Nombre del Empleado
y Título del Trabajo _____

Fecha del Incidente _____

Hora Del Incidente _____

Descripción del Incidente

Por favor, use tantos detalles como sea posible. Incluya la ubicación, el tipo de equipo en uso, la ropa, los zapatos, el estado de los pisos, el clima y el lugar donde se encontraba con respecto al incidente. Agregue más páginas según sea necesario:

_____

_____

_____

_____

_____

Firma del Testigo Fecha

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Workers' Compensation Fraud

Definition: Workers' compensation fraud laws make it a felony for anyone to file a false or fraudulent statement or to submit a false report or any other document for the purpose of obtaining or denying workers' compensation benefits. Anyone caught performing these illegal acts will be prosecuted. If convicted, the person can face up to 5 years in prison and/or $50,000 or double the value of the fraud, whichever is greater.

Statement

In an effort to keep our workers' compensation program fair for all, we must guard against fraud. Filing a worker's compensation claim means you were injured on the job and not elsewhere. This means you have no doubt that your injury occurred on the job.

Furthermore, you are required by California State Law to provide the true facts. Information that is false, inaccurate, withheld or exaggerated could constitute workers' compensation fraud.

Each filed claim is reviewed and may be fully investigated. If any of the facts are found to be false, inaccurate, withheld or exaggerated, disciplinary action including termination will be taken. Legal action may also be taken. We bring these matters to your attention because workers' compensation fraud is against the law.

Workers' Compensation Fraud

Chapter 12 of the California Insurance Code, Section 1871.4(a) makes it unlawful to do any of the following:

- Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.
- Present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, a claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.
- Knowingly assist, abet, conspire with, or solicit a person in an unlawful act under this section.
- Make or cause to be made a knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.
- For the purposes of this subdivision, "statement" includes, but is not limited to, a notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.
    - Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.
    - Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

Chapter 12 of the California Insurance Code, Section 1871.4(b) specifies punishment for a violation of subsection (a) as follows:

- Imprisonment in County Jail for one year; or
- Imprisonment in the State Prison for 2, 3, or 5 years; or
- Fine not exceeding $50,000 or double the value of the fraud, whichever is greater; or
- Both imprisonment and fine.

Restitution shall also be ordered, and the person convicted may be charged the costs of investigation.

Under California Penal Code Section 550 (a)(1), it is unlawful to "knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance". Anyone who violates this subsection is guilty of a felony, punishable, as specified in section 550(c)(1), by:

- Imprisonment in the State Prison for 2, 3, or 5 years; and
- a fine not exceeding $50,000 or double the amount of the fraud, whichever is greater.

I have read the statement above and understand that workers' compensation fraud is against the law.

_____	_____	_____
Signature	Print Name	Date

Fraude de Compensación a los Trabajadores de California

Definición: Las leyes de fraude de compensación laboral hacen que sea un delito para cualquier persona presentar una declaración falsa o fraudulenta o presentar un informe falso o cualquier otro documento con el fin de obtener o denegar los beneficios de compensación laboral. Cualquiera que sea sorprendido realizando estos actos ilegales será procesado.

Si es declarado culpable, la persona puede enfrentar hasta 5 años de prisión y/o $50,000 o el doble del valor del fraude, el que sea mayor.

Declaración

En un esfuerzo por mantener nuestro programa de compensación para trabajadores justo para todos, debemos protegernos contra el fraude. Presentar un reclamo de compensación laboral significa que usted se lesionó en el trabajo y no en otro lugar. Esto significa que no tiene dudas de que su lesión ocurrió en el trabajo.

Además, la ley del estado de California le exige que proporcione los hechos reales. La información que es falsa, inexacta, retenida o exagerada podría constituir fraude de compensación laboral.

Cada reclamo presentado se revisa y puede investigarse completamente. Si se descubre que alguno de los hechos es falso, inexacto, retenido o exagerado, se tomarán medidas disciplinarias, incluida la terminación. Acción legal también puede ser tomada. Traemos a su atención estos asuntos porque el fraude de compensación al trabajador es contrario a la ley.

Fraude de Compensación a los Trabajadores de California

El Capítulo 12 del Código de Seguros de California, Sección 1871.4(a) establece que es ilegal hacer cualquiera de los siguientes:

- Hacer o hacer que se haga a sabiendas una declaración material falsa o fraudulenta o una representación material con el propósito de obtener o denegar cualquier compensación, como se define en la Sección 3207 del Código Laboral.
- Presentar o hacer que se presente una declaración escrita u oral a sabiendas falsa o fraudulenta en apoyo de, o en oposición a, un reclamo de compensación con el propósito de obtener o denegar cualquier compensación, según se define en la Sección 3207 del Código Laboral.
- A sabiendas ayude, instigue, conspire o solicite a una persona en un acto ilegal bajo esta sección.
- A los fines de esta subdivisión, la "declaración" incluye, entre otros, un aviso, prueba de lesión, factura por servicios, pago de servicios, registros hospitalarios o médicos, rayos X, resultados de pruebas, gastos médico- legales como se define en la Sección 4620 del Código del Trabajo, otra evidencia de pérdida, lesión, gasto o pago.
    - Hacer o hacer que se haga una declaración falsa o fraudulenta a sabiendas con respecto a la titularidad de los beneficios con la intención de desalentar a un trabajador lesionado de reclamar beneficios o presentar un reclamo.
    - Hacer o hacer que se haga a sabiendas una declaración material falsa o fraudulenta o una representación material con el propósito de obtener o denegar cualquiera de los beneficios o reembolsos provistos en el Programa de Regreso al Trabajo establecido en la Sección 139.48 del Código del Trabajo.

El Capítulo 12 del Código de Seguros de California, Sección 1871.4 (b) especifica el castigo por una violación de la subsección (a) de la siguiente manera:

- Encarcelamiento en la cárcel del condado por un año; o
- Encarcelamiento en la prisión estatal por 2,3 o 5 años; o
- Multa que no exceda los $50,000 o el doble del valor del fraude, el que sea mayor; o
- Ambos, encarcelamiento y multa.

La restitución también se ordenará, y la persona condenada puede ser acusada de los costos de la investigación.

Según la Sección 550 (a) (1) del Código Penal de California, es ilegal "presentar de manera encubierta o hacer que se presente un reclamo falso o fraudulento por el pago de una pérdida o lesión, incluido el pago de una pérdida o lesión conforme a un contrato de seguro".

Cualquier persona que viole esta subsección es culpable de un delito grave, punible, como se especifica en la Sección 550 (c) (1), por:

- Encarcelamiento en la prisión estatal por 2, 3 o 5 años; y un
- Multa que no exceda los $50,000 o el doble del monto del fraude, el que sea mayor.

He leído la declaración anterior y entiendo que el fraude de compensación laboral es contrario a la ley.

_____	_____	_____
Imprimir Nombre	Firma	Fecha

Modified Duty:

Temporary Transitional Return-to-Work Job Offer

Your physician, Dr. _____, has released you to temporary transitional work. We have located a temporary position that you should be able to perform. Your need for continuing in this position will be periodically reevaluated.

Injured Information:

Employee Name _____

Date _____

Insurance Co./Claim Num. _____

Address _____

Work Restrictions _____

_____

_____

_____

Job Modifications or Transitional Work Assignments _____

_____

_____

Schedule & Wages:

Days per week: _____ Days of week: ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat ☐Sun (mark)

Number of hours per shift: _____ From _____ am/pm to _____ am/pm (circle) You will be receiving $ _____ per hour. The claim administrator will prorate your workers' comp. benefits if salary or work hours are less than your regular wage & hours.

The assignment begins on _____ (date) with reevaluation on _____ (date).

We ask that you report for work on _____ (date) at _____ am/pm

Report to: _____ Department: _____ Phone:_____

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If you receive this letter after the report-to-work date, you have **24-hours** to contact the following person:

_____

We look forward to seeing you and wish you rapid recovery.

Sincerely,

_____ _____
Workers' Comp Coordinator Title/Department

_____ _____
Phone Signature

_____
Date

Facility: send this letter via certified and regular mail, or have the employee come to your office to sign and date it. Attach doctor's work status report.

Employee Section

A rejection of a transitional job may constitute no payment of temporary disability payments from the workers' compensation insurance company. Please contact work comp coordinator or claim examiner for benefit information.

The State of California also offers free assistance via their Information & Assistance Offices located throughout the State. You may call (800) 736-7401 for additional information.

I have read and understand the information above. I accept this job as offered:

☐ Yes ☐ No

_____ _____
Employee's Signature Date

_____
Phone Number

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Trabajo Modificado:

Oferta de trabajo temporal de transición al trabajo

Su médico, el/la Dr. _____, lo liberó para un trabajo temporal de transición. Hemos localizado una posición temporal que debería poder realizar. Su necesidad de continuar en este puesto será reevaluada periódicamente.

Información del Empleado:

Nombre del Empleado _____

Fecha del Incidente _____

Compañía de seguros / número de reclamo _____

Dirección _____

Restricciones de Trabajo (describa a continuación o adjunte informe de estado de trabajo) _____

_____

_____

Modificaciones de trabajo o asignación de trabajo de transición (describa a continuación o adjunte responsabilidades) _____

_____

_____

Horario y Salarios:

Días por semana: ____ Días de la Semana: ☐Lun ☐Mar ☐Mier ☐Ju ☐Vier ☐Sab ☐Dom (marca)

Número de horas por turno: _____ De _____ am/pm a _____ am/pm (circule)

Usted recibirá $ _____ por hora. El administrador de reclamos prorrateará los beneficios de compensación de sus trabajadores si el salario o las horas de trabajo son inferiores a su salario y horas regulares.

La tarea comienza en _____ (fecha) con reevaluación en _____ (fecha).

Le pedimos que se presente para trabajar en _____ (fecha) a las _____ am/pm.

Usted se reportará a: _____ Departamento: _____ Teléfono: _____

Si recibe esta carta después de la fecha del informe para trabajar, tiene 24 horas para contactar a la siguiente persona:

_____

Esperamos verte y deseamos una recuperación rápida.

Sinceramente,

_____ _____
Coordinador de compensación laboral Título/Departamento

_____ _____
Teléfono Firma

_____
Fecha

Facility: send this letter via certified and regular mail, or have the employee come to your office to sign and date it. Attach doctor's work status report.

Sección de Empleados

Un rechazo de un trabajo de transición puede constituir una falta de pago de la compañía de seguros de compensación de trabajadores por pagos de incapacidad temporal. Comuníquese con el coordinador de compensación de trabajadores o el examinador de reclamaciones para obtener información sobre los beneficios.

El Estado de California también ofrece asistencia gratuita a través de sus Oficinas de Información y Asistencia ubicadas en todo el estado. Puede llamar al (800) 736 - 7401 para obtener información adicional.

He leído y entiendo la información anterior. Acepto este trabajo como se me ofrece:
☐ Si ☐ No

_____ _____
Firma del Empleado Fecha

_____
Teléfono