WorkAbility I

Parent/Guardian Permission for Student Participation

I_____ have been given a copy of:

- WorkAbility I Packet Instructions
- Parent/Student Training Site Letter
- Child Labor Laws (if under 18)
- WorkAbility I Student Emergency Card
- W-4 and Emergency Form (HRD – Green forms)
- Social Security Card and Picture I.D. Documentation (HRD – Pink forms)
- Student/Parent Media Release (Pink form)
- Student Agreement (Yellow form)
- Emergency Contacts and Procedures
- TVUSD Payroll Schedule

I give permission for my son/daughter, _____ to participate in the WorkAbility I program.

_____

Parent/Guardian Signature / Date

Student Name:_____
Parent/Guardian Name:_____
Phone Number:_____

WorkAbility I

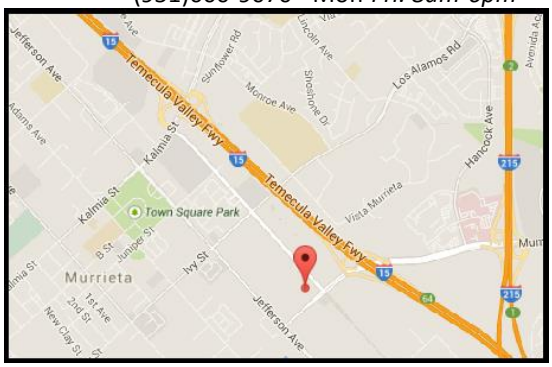
Emergency Contacts and Procedures

For Students:

1. Students must report all injuries IMMEDIATELY to the Teacher, Job Coach, or Supervisor. Notify WorkAbility I at (951)506-7070 Bridget Denton or Itza Chavira. Also, report the incident to the Risk Management Dept. at (951)506-7075. Even if medical treatment is not required, the incident should be reported.

2. If medical treatment is required, the student should go to:

U.S. HealthWorks
25285 Madison Ave. Suite 101 Murrieta
(951)600-9070 - Mon-*Fri. 8am-6pm*



Inland Urgent Care
31365 Rancho Pueblo, Suite 102 Temecula
(951) 303-6440 - Mon-*Sun. 9am-8pm*

24 Hour Urgent Care
41715 Winchester Road, Temecula
(951)308-4451 - 24*hours/day 7days/week*

3. If medical treatment becomes necessary the supervising staff should give the student a form called “Employee’s Claim for Workers’ Compensation Benefits” (DWC Form 1). The student must complete lines 1-8 on this form, and then the form must be signed by the Supervising Staff in order for them to be eligible to receive medical benefits.

4. Give no information concerning injuries to anyone other than Risk Management, Fiscal Department Supervisors, or Keenan & Associates. Refer all other such inquiries to Risk Management Dept. at (9510)506-7570

WorkAbility I

For Staff Supervising Students:

1. Make sure the students has been informed of the proper procedure to follow in the event of an industrial accident (NO's 1-4 on emergency contacts and procedures)

2. Within 24 hours from the time you are informed that an employee is injured on the job, give him/her the "Employee's Claim for Worker's Compensation Benefits" (DWC Form 1) form ***if they require medical attention.***

3. If medical treatment is required, send the student to one of the facilities on reverse.

4. If medical treatment is required, send the student to one of the facilities on reverse.

5. If medical treatment is required, call the Risk management Dept. at (951) 506-7075

6. Give no information concerning injuries to anyone other than the Risk Management Dept., Fiscal Department Supervisors, or Keenan & Associates. Refer all other such inquiries to the Risk Management at (951)506-7075

Temecula Valley Unified School District
31350 Rancho Vista Road
Temecula, CA 92591

Risk Management/Worker's Compensation
(951)506-7075 (951)294-6260 fax

AUTHORIZATION FOR MEDICAL TREATMENT
Work-Related Employee Injury

Employee name:_____ **Site:**_____
Date of Injury:_____ **Time:**_____**am / pm** **Work Hours:**_____

IMPORTANT-CHOOSE ONE OPTION LISTEN BELOW:

☐ **I ACCEPT** treatment at a clinic designated by the Temecula Valley Unified School District as listed below. Please select one of the doctors listed below by placing a check mark in the appropriate box.

☐ I choose to be treated by the **PRE-DESIGNATED PHYSICIAN**, as noted below. I understand that this designation must be on file with to District Risk Management Department prior to the date of this injury and that the physician I have chosen has previously treated me and has my medical records. Additionally, s/he must agree to accept Worker' Compensation cases.

Note: Use of an unauthorized medical facility may result in non-payment of the bill.

✓	*Name*	*Address*	*Phone*	*Hours*
☐	U.S. HealthWorks	25285 Madison Ave. Suite 101 Murrieta	(951)600-9070	Mon-Fri. 8am-6pm
☐	Inland Urgent Care	31365 Rancho Pueblo, Suite 102 Temecula	(951) 3036440	Mon-Sun. 9am-8pm
☐	24Hour Urgent Care	41715 Winchester Road, Temecula	(951)308-4451	24hours 7days a week
☐	Pre-Designated Physician	*This option available only if you filed with Risk management a pre-designated form signed by your physician prior to injury.*		

I HAVE BEEN GIVEN THE FOLLOWING:
1) State Claim Form DWC-1 (copy)
2) Medical Treatment Authorization (copy)
3) Covered Empl Notification of Rights materials
4) Instructions for Injured Workers (copy)

EMPLOYEE SIGNATURE:_____ **DATE:**_____

AUTHORIZED BY:_____ **DATE:**_____

INSTRUCTIONS TO PROVIDER:

Mail Original Doctors First Report and All Medical Bills to:
Risk Management (951)506-7075 (phone)
31350 Rancho Vista Road (951)294-6260 (fax)
Temecula, CA 92592

Distribution: Original to Medical Provider **FAX COPY TO: Risk Mgmt (951)294-6260** **Copy to: Employee/Work Site**

PREDESIGNATION OFPERSONAL PHYSICIAN

In the event you sustain an injury or illness related to our employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- Your employer offers group health coverage;
- The doctor is your regular physical, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner and has previously directed your medical treatment and retains your medical records;
- Your "personal physician" may be a medical group providing comprehensive medical services integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- Prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work – related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section

To:_____(name of employer) If I have a work related injury or illness, I choose to be treated by:

_____

(Name of doctor) (M.D., D.O., or medical group)

_____(Street address, city, state, ZIP)

_____(Telephone number)

Employee Name (please print):

Employee's Address:

_____

Employee's
Signature_____ Date:_____

Physician: I agree to this Predesignation

Signature:_____ Date:_____

(Physician or Designated Employee of the Physician or medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 march 1, 2007