ACCLAMATION INSURANCE MANAGEMENT SERVICES

WORKERS' COMPENSATION INJURY REPORT PACKET
For the City of Oxnard

Please Follow the Instructions Below to Report a Job-Related Injury:

1. COMPLETE the Report of Occupational Injury or Illness (CA Form 5020)

To be filled out by the Supervisor or Manager.

2. COMPLETE the Employee's Claim for Workers' Compensation Benefits (CA Form DWC-1)

Employee: Complete the **"Employee"** section and give the form to your Supervisor.
Supervisor: Once the Employee completes the top portion and returns the form, complete the bottom portion. It is very important that **all dates** required be completed. Once the form is completed, provide a copy to the employee. This should take place within **one working day** of the injury.

3. COMPLETE the Body Diagram

Employee: Complete the **"Employee"** section and give the form to your Supervisor.

4. COMPLETE the Supervisor's Incident Investigation Report

To be filled out by the Supervisor or Manager.

5. COMPLETE the Physician's Notice of Return to Work/Temporary Medical Restrictions

The form is to be given to the injured Employee, who will take the form to the medical facility to be filled out by medical facility staff. The injured Employee is responsible for returning the completed form to the Supervisor for forwarding to AIMS.

6. OPTIONAL: COMPLETE the Temporary Modified Duty Agreement

If the employee requires modified duties due to the injury, the Employee and Supervisor must meet with Human Resources Department staff to review and sign the modified duty agreement prior to employee being accommodated with work restrictions.

7. PROVIDE: Notice of Workers' Compensation Benefits

Employee can choose one of the listed preferred medical providers.

8. PROVIDE: First Fill Prescription Form

This form is an instant access card for the initial (first) prescription fill.

9. OPTIONAL: Voluntary Pre-designation Form

To treat with your personal physician for a work related injury, a completed/signed **Predesignation of Personal Physician** form must be on file **prior** to the date of injury.

10. SCAN all completed forms, in color, to AIMS and Risk Management staff:

Via email: newreports@AIMS4claims.com, mike.more@oxnard.org,

alex.juarez-pina@oxnard.org, and john.hanes@oxnard.org

Or via fax: (916) 563.1919 and (805) 385.8352

ATTACHMENTS

1. Report of Occupational Injury or Illness (CA Form 5020)
2. Employee's Claim for Workers' Compensation Benefits (CA Form DWC-1)
3. Body Diagram
4. Supervisor's Incident Investigation Report
5. Physician's Notice of Return to Work/Temporary Medical Restrictions
6. Temporary Modified Duty Agreement
7. AIMS Medical Provider Notice
8. Prescription Drug Program Instant Access Card for Your First Prescription Fill
9. Voluntary Pre-designation Form
10. Employee Fact Sheet – Workers' Compensation
11. Time of Hire Workers' Compensation Pamphlet

NOTICE: 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.

QUESTIONS AFTER AIMS/CITY BUSINESS HOURS WHEN INITIATING A NEW CLAIM, CONTACT:
Pam Schierman, RN, NCM, via telephone: 805-644-8845.