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.

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

***Empleado:*** *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

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

**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.* _____
10. Address. *Dirección.* _____
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.*
    Tristar Risk Management P.O. Box 7937 Fresno, CA 93747
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.

GNING 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*

7/1/04 Rev.

6-1 a.

# EMPLOYEE'S REPORT OF INJURY OR ILLNESS

Return this form to your supervisor

Employee's name _____

Job Position/Title _____ Social Security Number _____- _____- _____

Shift hours _____ Days off _____ Supervisor's name _____

Date and time of injury or illness _____ Location _____

Task being performed when injury occurred _____

Date and time injury or illness reported _____ To whom? _____

Name(s) of witness (es) _____

_____

Describe how the injury or illness occurred:

_____

_____

_____

What part of the body was affected?

_____

Describe the injuries or illness in detail:

_____

_____

_____

_____

Date, time you first sought medical attention:

_____

Name of doctor and/or hospital:

_____

Could anything be done to prevent occurrences of this type? If so, what?

_____

_____

_____

_____ _____

Signature of Employee Date

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# SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Return this form and the Employee's Report of Injury or Illness to the departmental safety officer

Employee's name _____ Social Security Number _____- _____ - _____

Job position/title _____ Supervisor's name _____

Date and time of injury or illness _____ Location _____

Task being performed when injury occurred _____

Date and time injury was reported to you _____

Name(s) of witness(es) _____

_____

Accident resulted in: Injury _____ Fatality _____ Property damage _____

First aid given? _____ Medical treatment required? _____ Workdays lost _____

Describe how the injury or illness occurred:

_____

_____

_____

What actions, events, or conditions contributed most directly to this injury or illness?

_____

_____

_____

Could anything be done to prevent occurrence of this type? If so, what?

_____

_____

_____

_____ _____

Signature of Supervisor Date

_____ _____

Signature of Safety Officer Date

Comments:

_____

_____

**STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS**
**Division of Workers' Compensation**

# Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

**Benefits.** Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering.
- **Permanent Disability (PD) Benefits:** Payments if your injury causes a permanent disability.
- **Vocational Rehabilitation:** Services and payments if your injury prevents you from returning to your usual job or occupation. This benefit applies to injuries that occurred prior to 1/1/04.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

**Naming Your Own Physician Before Injury.** You may be able to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury . If eligible, you must tell your employer, in writing, the name and address of your personal physician *before* you are injured. For instructions, see the written information about workers' compensation that your employer is now required to give to new employees.

**If You Get Hurt:**

1. **Get Medical Care.** If you need first aid, contact your employer. If you need emergency care, call for help immediately. Emergency phone numbers:

   Ambulance _____ Fire Dept. _____ Police _____

   Doctor _____ Hospital _____

2. **Report Your Injury.** Report the injury immediately to your supervisor or to:
   Employer representative _____ phone number _____.
   Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you named your personal physician before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information.

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

**Questions?** Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator _____

Address _____ City _____ State ____ Zip _____

Phone _____ Policy Expiration Date _____

The employer is insured for workers' compensation by _____
(Enter "self-insured" if appropriate)

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement - their number can be found in your local White Pages under California State Government, Department of Industrial Relations.

You can get free information from a State Division of Workers' Compensation Information & Assistance Officer.
The nearest Information & Assistance Officer is at:

Address _____ City _____ Phone _____

Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401**. Learn more online: **www.dir.ca.gov.**

**False claims and false denials.** 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

DWC 7 (8/1/04)

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| State of California<br>**EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS** | **After completion, please send two (2) copies to:**<br>TRISTAR Risk Management<br>P.O. Box 7937, Fresno, CA 93747 | **OSHA CASE NO.**<br>**FATALITY** ☐ |
|---|---|---|

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose to 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 | 1A. Policy Number | **Please do not use this Column** |
|---|---|---|
| 2. MAILING ADDRESS (Number and Street, City, ZIP) | 2A. Phone Number | CASE NUMBER |
| 3. LOCATION If different from Mailing Address (Number And Street, City, ZIP) | 3A. Location Code | |
| 4. NATURE OF BUSINESS, e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc. | 5. State unemployment insurance acct. no. | OWNERSHIP |
| 6. TYPE OF EMPLOYER<br>☒ Private ☐ State ☐ County ☐ City ☐ School Dist. ☐ Other Government, Specify: ____ | | INDUSTRY |

**INJURY OR ILLNESS**

| 7. DATE OF INJURY/ONSET OF ILLNESS (mm/dd/yy) | 8. TIME OF INJURY/ILLNESS OCCURRED ☐ AM ☐ PM | 9. TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy) | OCCUPATION |
|---|---|---|---|---|
| 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 IN FULL DAYS WAGES FOR DATE OF INJURY 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 (mm/dd/yy) | SEX |
| 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. | | | | AGE |
| 20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) | 20a. COUNTY | 21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No | | DAILY HOURS |
| 22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop. | 23. Other Workers Injured/Ill in this event? ☐ Yes ☐ No | | | DAYS PER WEEK |
| 24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: | | | | WEEKLY HOURS |
| 25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck. | | | | WEEKLY WAGE |
| 26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY. | | | | COUNTY |
| 27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip) | | 27a. PHONE NUMBER | | NATURE OF INJURY |
| 28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ Yes ☐ No<br>If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip). | | 28a. Phone Number | | PART OF BODY |
| | | 29. Employee treated in Emergency Room? ☐ Yes ☐ No | | SOURCE |

**EMPLOYEE**

**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 indicated confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

| 30. EMPLOYEE NAME | 31. SOCIAL SECURITY NUMBER | 32. DATE OF BIRTH (mm/dd/yy) | EVENT |
|---|---|---|---|
| 33. HOME ADDRESS (Number, Street, City, Zip) | | 33a. PHONE NUMBER | SECONDARY SOURCE |
| 34. SEX | 35. OCCUPATION (Regular job title, NO initials, abbreviated or numbers) | 36. DATE OF HIRE (mm/dd/yy) | |
| 37. EMPLOYEE USUALLY WORKS<br>_____ hours per day, _____ days per week, _____ total weekly hours | 37a. EMPLOYMENT STATUS | 37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED? | EXTENT OF INJURY |
| 38. GROSS WAGES/SALARY<br>$_____ per | 39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No | | |

| Completed By (type or print) | Signature & Title | DATE (mm/dd/yy) |
|---|---|---|
| | | |

*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.



FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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# Employers Reporting Responsibilities to Cal/OSHA

Effective January 1, 2003, the minimum civil penalty was increased to $5,000 for failure to report a fatality or serious injury or illness to the Division as required by section 342 of Title 8 of the California Code of Regulations. The reporting requirements have not changed, only the amount of the penalty. For your information the following is a summary of the reporting requirements:

Incidents requiring reporting to the Division within eight (8) hours:

- Fatal injury to an employee
- Serious injury or illness to employee

A serious injury or illness is defined as:

- Loss of a member of the body (e.g., amputation); or
- Serious degree of permanent disfigurement (e.g., crushing or severe burn type injuries); or
- In-patient hospitalization in excess of 24 hours for other than observation,

Employers are not required to report any injury or illness or death caused by an accident on a public street or highway, or by the commission of a Penal Code violation, except a violation of section 385 of the Penal Code.

If a fatal or serious injury or illness to an employee occurs, the employer must report by telephone or fax to the nearest district office of the Division (refer to Cal/OSHA poster) not longer than eight (8) hours after the employer knows or with diligent inquiry would have known of the incident. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident.

Information required to be reported to Cal/OSHA:

1. Time and date of incident
2. Employer's name, address and telephone number
3. Name and job title of person reporting the accident
4. Address of the site where the incident occurred
5. Name of person to contact at incident site
6. Name and address of injured employee
7. Nature of injury
8. Location of where injured employee was taken
9. Identity of law enforcement agencies present at the site of the incident
10. Description of the incident

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**Examples of Major Injuries/Illnesses (OSHA Recordable):**

- Chest pain
- Difficulty breathing
- Loss of, or change in, level of consciousness
- Severe burns
- Head or neck injury
- Penetrating wound of chest or abdomen
- Amputation
- Allergic reaction with tightness in throat, difficulty breathing, or dizziness
- Severe bleeding
- Obvious fracture with deformity
- Falls of greater than 4 feet
- Penetrating eye injuries
- Toxic chemical exposures (swallowing, inhalation, skin contact); send MSDS
- Multiple injuries
- Psychiatric disturbances (hallucinations, delusions)
- Seizure
- Lacerations (cuts) exceeding 2 inches in length
- Any injury that results in lost time or restricted duty
- Death

**CAL/OSHA REPORTING OF SERIOUS ILLNESS, INJURY OR DEATH OF AN EMPLOYEE**

WHEN CALLING CAL/OSHA THEY WILL WANT THE FOLLOWING INFORMATION:

***Cal/OSHA Enforcement Unit –*** ***Phone #***_____
***Fax #***_____

1. TIME AND DATE OF INCIDENT:

_____

2. EMPLOYER'S NAME, ADDRESS, AND TELEPHONE NUMBER:

_____

3. NAME AND TITLE OF PERSON REPORTING THE INCIDENT:

_____

4. ADDRESS WHERE INCIDENT OCCURRED:

_____

5. NAME OF PERSON TO CONTACT AT INCIDENT SITE:

_____

6. NAME AND ADDRESS OF INJURED EMPLOYEE:

_____

_____

_____

7. NATURE OF INJURY:

_____

8. LOCATION WHERE INJURED EMPLOYEE WAS TAKEN:

_____

9. LIST AND IDENTIFY LAW ENFORCEMENT AGENCIES PRESENT AT THE INCIDENT SITE:

_____

10. DESCRIPTION OF INCIDENT:

_____

_____

_____

THE ABOVE INFORMATION WAS TRANSMITTED TO _____ (NAME)
AT THE OSHA OFFICE ON _____ (DATE) AT _____ (TIME) BY _____

# BASIC RULES FOR ACCIDENT INVESTIGATION*

- The purpose of an investigation is to find the cause of an accident and prevent further occurrences, not to fix the blame. An unbiased approach is necessary to obtain objective findings.

- Visit the accident scene as soon as possible while the facts are fresh and before witnesses forget important details.

- If possible, interview the injured worker at the scene of the accident and "walk" him or her through a re-enactment.

- All interviews should be conducted as privately as possible. Interview witnesses one at a time. Talk with anyone who has knowledge of the accident, even if they did not actually witness it.

- Consider taking signed statements in cases where facts are unclear or there is an element of controversy.

- Document details graphically. Use sketches, diagrams, and photos as needed, and take measurements if appropriate.

- Focus on causes and hazards. Develop an analysis of what happened, how it happened, and how it could be prevented. Determine what caused the accident itself, not just the injury.

- Every investigation should include an action plan. How will you prevent such accidents in the future?

- If a third party or defective product contributed to the accident, save any evidence. It could be critical to the recovery of claims costs.

* Every employer shall report immediately (within 24 hours) by telephone or telegraph to the nearest District Office of the Division of Occupational Safety and Health any serious injury or illness, or death of an employee occurring in a place of employment or in connection with any employment (see Cal. Code Reg., tit. 8, § 342)

## STEPS TO TAKE WHEN YOU ARRIVE AT ACCIDENT SCENE

### GET BRIEFED

- When you first arrive at the scene, talk to the persons who first responded and/or who were at the scene when the accident occurred.

### PHOTOGRAPHY

- Document any accident scene.
- No. 1 Rule: YOU CAN NEVER TAKE TOO MANY PICTURES
- It is very important you try to keep the site of the accident from being contaminated by people walking through the scene, touching, cleaning, moving items, etc.
- Lighting is very important to pick up details correctly – learn to use your flash
- Become familiar with your equipment
- Pointing with the camera (get all points of reference of the scene)
- Sequence for photos
  - overall shot – "orientation photographs"
  - mid-range
  - close up (fill the frame with the item being photographed)

## HOW TO PREPARE A REPORT

- Mentally review as much as you know about the case.
- Write in first person.
- Don't leave gaps in report.
- Write a rough draft first.
- Immediately after an interview, put information into report format.

## WHAT TO LOOK FOR IN A GOOD REPORT

- Make sure you yourself can read it an understand it.
- Don't use "legalese"
- Use interviewee's exact words whenever possible.
- Should be easy to read and make sense.
- Long report does not mean good report. Get to the point – be succinct.

## WHAT TO LOOK FOR IN A BAD REPORT

- "Creative report writing"
- Writing things because you think it's what the report recipient wants to hear.
- Makes no logical sense.

# INTERVIEWING AND INVESTIGATIONS

## I. Do good interviews

A. Prepare for the interview
- Call to make an appointment for interview, esp. if professional
- Have in mind what you're looking for
- If available read everything you can before interview (statements, report, etc.)
- Have paper, pen/pencil, film, batteries, tape, etc.

B. Establish good interview techniques
- HAVE TO BE ABLE TO LISTEN
- Treat each interview as very important and different
- Give each interview your best every time
- Don't assume by the way someone dresses they're smart/dumb
- Don't assume anything with an interview
- After each interview, review your notes
- Look for quality, not quantity, in interview notes
- Always ask for other witnesses "do you know anybody else..."
- Be honest why you want to interview them
- Interview "in person" if possible

## II. Conducting the interview

A. Dress for an interview
- Always dress professionally
- Always dress appropriately – match circumstance
- The way you dress sets a tone for the school

B. Conducting the interview
- Interview one person at a time
- Introduce yourself
- Tell them why you are there
- Let them tell their story – do not take notes, do not try to influence
- Then ask questions/take notes
- Make sure environment is appropriate for interviewing (minimum interruptions, noise, etc.)
- Don't chew gum, tap fingers, etc.
- List people in attendance at interview with addresses and phone numbers
- If there is a language barrier, hire a professional, court-qualified interpreter
- Let them give you their story first, don't correct them

- If you know someone is lying, let them lie, don't try to get them to change their story (can later be impeached)
- After you've taken notes, write out report immediately

C. When and where to conduct interview
- Conduct interview where it will work best, where the person is comfortable
- Know the interviewee will probably be nervous
- Try to bring into your office to a controlled environment
- If you go to the interviewee, tell them to hold calls / interruptions

## III. Techniques for questioning

A. Ask one question at a time
- Let them answer before going on

B. If two people are conducting the interview, only one person talks, the other can take notes
- When done, ask the other interviewer if they have any additional questions

C. Avoid the implied answer, don't suggest an answer

D. Keep the questions as simple as possible, rephrase if the interviewee does not understand

E. Never insist on a "yes" or "no" answer; you can get very inaccurate results
- Yes/No questions break the flow of information
- Have the interviewee qualify a Yes/No response

F. If the interviewee starts to digress – get them back on point

G. Keep a positive attitude

# Indicators of Possible Workers' Compensation Fraud "Red Flags"

Although most claims are legitimate, some are inflated or fraudulent, and the district should review all claims to prevent the accident from happening again or for possible fraud. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud has been committed.

- The injured worker is a new hire.
- The applicant took unexplained or excessive time off prior to claimed injury.
- The alleged injury occurs prior to, or just after a layoff, job termination, or completion of seasonal/temporary work/notice of employer relocation.
- Applicant reports an alleged injury immediately following disciplinary action, notice of probation, demotion, or being passed over for promotion.
- Applicant has a history of personal injury, workers' compensation claims, and/or of reporting "subjective" injuries.
- The alleged injury relates to a preexisting injury or health problem.
- Applicant has a high-risk activity, such as skydiving, or bungee-jumping as a hobby.
- The applicant's version of the accident has inconsistencies.
- There are no witnesses to the accident or witnesses to the accident conflict with the applicant's version or with one another.
- Applicant fails to report the injury in a timely manner.
- Accident or type of injury is unusual for the applicant's line of work.
- Facts regarding accident are related differently in various medical reports, statements, and employer's first report of injury.
- Applicant cannot be reached at home during working hours, although claims to be disabled from working. The person receiving calls appears vague and non-committal. Applicant is otherwise unavailable and elusive.
- Applicant's co-workers express opinion that injury is not legitimate.
- Injured worker is involved in seasonal work that is about to end.
- Injured worker takes more time off than the claimed injury seems to warrant.
- Injured worker is nomadic and has a history of short-time employment.
- Injured worker changes physicians when a release for work has been issued.
- Injured worker has a history of reporting subjective injuries.
- Accident occurs late Friday after noon or shortly after the employee reports to work on Monday.
- Accident is unwitnessed.
- Claimant has leg/arm injuries at odd time, i.e. at lunch hour.
- Fellow workers hear rumors circulating that the accident was not legitimate.
- Accident occurs in areas where injured employee would not normally be.
- Accident is not the type that the employee should be involved in, i.e. office worker who is lifting heavy objects on a loading dock.
- Employer's first report of claim contrasts with description of accident set forth in medical history.
- Details of accident are vague.
- Incident is not promptly reported by employee to supervisor.
- After injury, injured worker is never home or spouse/relative answering phone states the injured worker "just stepped out."
- Return calls to resident have strange or unexpected background noises.

# Investigation Requests

The majority of our workers compensation claims are legitimate. However, if you have a reason to suspect a claim might be exaggerated, fraudulent or not work related, a thorough investigation should be conducted. Please contact your claims manager to facilitate the workers compensation claims investigation process:

**REQUEST FOR SUB ROSA INVESTIGATION (SURVEILLANCE)**

Sub Rosa *aka* Surveillance, which consists of monitoring the subject's activities and recording, via video and visual observation, any actions relevant to the case.

**REQUEST FOR AOE/COE INVESTIGATION**

Consist of interviewing the claimant, interviewing any potential witnesses to the alleged incident/work-related injury, as well as obtaining any necessary photographs and/or relevant documentation.

***Note***: *The term AOE/COE refers to determining if a work comp injury is "**A**rising **O**ut of **E**mployment" or it is in the "**C**ourse **O**f **E**mployment."*

# REQUEST FOR SUB ROSA INVESTIGATION (SURVEILLANCE)

Requestor:_____

**District Information**

District:_____ Address: _____

District Contact:_____Title: _____

Phone: _____ Email: _____

**Claimant Information**

Claimant:_____ Home Address: _____

Phone: _____Date of Birth:_____ SSN:_____

Sex: ___Height: _____ Weight: _____ Hair length/color:_____ Eye color:_____

Physical Characteristics (mustache, glasses, limp, etc.) _____

_____

(Attach Photograph if available.)

Vehicle Description: _____ _____ _____ _____ _____

Make Model Year Color State & No. of license plate

**Injury Information**

Describe injury and part of body affected:_____

_____

_____

Has claimant seen any doctor(s)? _____ If yes, provide name and address: _____

_____

_____

Please attach or describe any information obtained from doctor(s):_____

_____

_____

**Describe Articulable Suspicion (reason) for request for subrosa investigation per Civil Code 1708.8:**

_____

_____

_____

_____

**FAX REQUEST TO:**_____-

6-26.