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To: Human Resources Directors

From: Cathy Robinson, Senior Director
Human Resources Administration

Subject: INDUSTRIAL DISABILITY LEAVE (IDL) ADMINISTRATIVE GUIDE-
REVISED DECEMBER 1997

Three copies of the revised Industrial Disability Leave (IDL) Administrative Guide are attached for use by your staff. This Administrative Guide, revised effective December 1997, replaces the IDL Administrative Guide dated June 1993. Also included with the Guide are updated resources which include recent changes in law regarding transfer of medical treatment and vocational rehabilitation. Please note that the Return to Work Policy Guidelines are not being reissued since all campuses have their programs in place.

There have been no significant changes in IDL policy. The intent of the revision of the Guide is to provide clarification of language and policy direction due to the addition of other leave programs and their impact on IDL.

Questions regarding IDL policy should be addressed to Pamela Chapin in Human Resources Administration. She may be reached at (562) 985-2652 or via E-mail at pam_chapin@calstate.edu.

Attachments

Distribution:

Presidents w/o Attachment
Interim Senior Director, Human Resources w/o
Associate Vice Presidents/Deans, Faculty and Staff Affairs w/Attachment
Benefits Officers w/Attachment
Workers’ Compensation Administrators w/Attachment
Payroll Officers w/Attachment
Systemwide ADA Coordinator w/Attachment
Systemwide Risk Manager w/Attachment
THE CALIFORNIA STATE UNIVERSITY

INDUSTRIAL DISABILITY LEAVE
ADMINISTRATIVE GUIDE

Prepared by:
Human Resources Administration
Office of the Chancellor
Revised: December 1997
# INDUSTRIAL DISABILITY LEAVE
## ADMINISTRATIVE GUIDE

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GENERAL INFORMATION

Reference: Education Code Sections 89529-89529.11

CSU employees who are members of the Public Employees Retirement System (PERS) or the State Teachers Retirement System (STRS) and who have suffered an industrial disability may be eligible to receive Industrial Disability Leave (IDL) in lieu of Workers’ Compensation Temporary Disability (TD) benefits. An eligible employee may receive IDL payments for a period not to exceed 52 weeks within two years from the first day of disability. The 52-week eligibility period is equivalent to 365 calendar days. One calendar day means any day during which the employee is on the IDL program (which includes days where partial benefits are received and may include weekends). However, IDL payments are based on the actual number of work days the disabled employee is absent from work. A holiday is counted as a work day. (Please refer to Appendix A for Education Code sections concerning Industrial Disability Leave.)

DESIGNATION OF RETURN-TO-WORK COORDINATOR

Each campus of The California State University shall designate a return-to-work coordinator and shall forward his/her name to the Governor’s Safety and Rehabilitation Program Office. The duties and responsibilities of the coordinator shall include but not be limited to ensuring that the disabled employee is informed of the benefits to which s/he is entitled to and to facilitate the employee’s early return to work.

ELIGIBILITY - General

An employee who is a member of the Public Employees Retirement System or the State Teachers Retirement System in compensated employment who becomes disabled due to an injury or illness arising out of or in the course of employment, within the meaning of Education Code Section 89529.5, shall be eligible to receive IDL benefits. Eligibility shall be contingent upon appropriate medical determination and the agreement of the employee to cooperate and participate in a reasonable vocational rehabilitation plan when furnished by The California State University. An employee shall become entitled, regardless of his/her period of service, to receive IDL payments, in lieu of Workers’ Compensation Temporary Disability (TD) payments with/without supplementation of appropriate leave credits.
A CSU employee who suffers a disability arising out of or in the course of CSU employment may receive IDL benefits if s/he meets all of the following conditions:

1.) Is an active PERS or STRS member, and

2.) Has a disability which has been verified and accepted by the State Compensation Insurance Fund (SCIF) as industrially caused, and

3.) Has chosen to receive IDL benefits in lieu of Workers’ Compensation Temporary Disability benefits or has failed to make a choice within 15 days from the date of the notice of benefit eligibility, and

4.) Has been unable to work as a result of injury or illness since:
   a.) the third calendar day of disability following the day of injury or illness, or
   b.) the first day the injured employee leaves work as a result of an injury growing out of a criminal act of violence against the employee, or
   c.) the first day of hospitalization, or
   d.) the day following the injury if the employee is absent from work because of the injury for more than 14 calendar days.

Each new, independent disability must be recorded separately with its own 52-week period. Recurrence of old disabilities do not entitle the disabled employee to a new 52-week IDL eligibility period.

**ELIGIBILITY - Delay in Determination**

Under certain circumstances, it may take some time before a determination can be made by SCIF as to whether an employee’s disability is or is not work-related. During this period, the employee should be allowed to use sick leave, vacation, and CTO leave credits as long as they are available. (The employee should also be encouraged to apply for NDL) After all leave credits have been exhausted, the individual will be placed on leave without pay status until a determination is reached. When it is determined the disability is job-related and the employee is eligible for IDL or Workers’ Compensation Temporary Disability, appropriate adjustments will be made to the employee’s account in accordance with the procedures of the particular program selected by the employee.
ELIGIBILITY - Medical Determination

The State Compensation Insurance Fund (SCIF) shall make all temporary disability determinations based on medical evidence in accordance with its authority under Section 11871 of the Insurance Code. Eligibility for IDL benefits shall be contingent upon the certification of disability by SCIF. Upon expiration of IDL benefits, SCIF shall determine whether disability continues to exist and shall further determine the disabled employee's eligibility to receive Workers' Compensation Temporary Disability (TD) benefits.

ELIGIBILITY - Waiting Period

The disabled employee must serve a three calendar-day waiting period after the date of injury before becoming eligible for Industrial Disability Leave benefit payments unless:

1.) The employee is disabled as a result of an injury growing out of a criminal act of violence against the employee, in which case the employee is eligible for IDL benefit payments from the first day of disability.

2.) The employee is hospitalized on the date of injury, in which case the employee is eligible for IDL benefit payments from the first calendar day following the date of injury.

3.) The employee is hospitalized later because of the disability, in which case the employee is eligible for IDL benefit payments from the first day of the three calendar-day waiting period.

4.) The employee is disabled for more than 14 calendar days, in which case the employee is eligible for IDL benefit payments from the first day of the three calendar-day waiting period.

The three calendar-day waiting period need not be consecutive. Partial days of absence relating to the disability shall be accumulated to full days toward the waiting period. On the date of injury, the disabled employee shall be compensated for the full amount of time s/he would have worked had the injury not occurred. The waiting period may begin on the day following the injury, or at a later date. The disabled employee shall be eligible for IDL benefit payments when the accumulation of time off completes the three calendar-day waiting period. The waiting period may include weekend days. This can occur at any time during the day. The three calendar-day waiting period is equivalent to 24 hours of scheduled work for an employee on an eight-hour work day schedule, 30 hours of scheduled work for an employee on a ten-hour work day schedule, and 36 hours of scheduled work for an employee on a twelve-hour work day schedule.
Absences from scheduled work during the three-day waiting period shall not be charged to IDL. Absences are to be charged against the employee's sick leave balance or other paid leave credits. If a non-exempt employee is out of leave credits, the salary must be docked. Exempt employees are charged leave credits for absences only on a full day basis based on the normal hours worked.

**BENEFITS - Choice**

A disabled employee shall have 15 calendar days from the mailing of the notice of benefit eligibility to notify his/her campus that s/he elects Workers' Compensation Temporary Disability (TD) benefits with or without supplementation, rather than IDL benefits. The employee's choice shall be retroactive to the first day of eligibility for disability benefits. Upon failure to respond within the time limit, the employee shall be placed on IDL unless TD benefits are greater. In such a case, the employee shall be determined to have rejected IDL in accordance with Education Code Section 89529.05, and all provisions of Workers' Compensation Temporary Disability shall apply.

If a disabled employee is incapable of making decisions for himself/herself, the campus or the disabled employee's spouse or representative shall request through the State Compensation Insurance Fund that the Workers' Compensation Appeals Board appoint a guardian or trustee in accordance with Section 5307.05 of the Labor Code. In such cases, the 15 calendar-day time limitation on the benefit choice provisions shall be waived.

Appendix B is an example of a benefits summary form that the campus may wish to reproduce and use as a guide while counseling an employee on choice of benefits.

**BENEFITS - Employee Waiver of Selection**

If a disabled employee waives his/her right to make his/her benefit selection, Education Code Section 89529.05 provides that s/he will receive IDL benefits unless Workers' Compensation Temporary Disability payments are greater, in which case all provisions of Workers' Compensation Temporary Disability shall apply.

**BENEFITS - Change**

Employees will be given a one-time opportunity to change benefits. At any time during the first 90 calendar days of absence, the disabled employee may notify his/her campus to change benefits from IDL to Workers' Compensation Temporary Disability benefits or vice versa. Such change shall be a one-time opportunity and shall be effective on the 90th calendar day of
Absence. The amount of benefit shall be that which the employee would have received on the 90th calendar day had the benefit been initially elected.

No later than the 60th calendar day of absence, the campus shall notify the disabled employee of his/her benefit modification rights provided for in this section. The employee must submit written notification of his/her desire to change benefits no later than the 90th calendar day of absence. Regardless of the change in benefits, the eligibility period for IDL benefits remains at 52 weeks within two years from the first day of disability. A failure of the employee to exercise his/her option by the 90th day shall result in no further opportunity for a change in benefits.

**BENEFITS - Garnishment**

Garnishment of IDL benefits may be only for court-ordered support payments. (Reference: State Controller’s Payroll Procedure Manual (PPM) Deduction Section.)

**BENEFITS - Expiration or Termination**

The campus Human Resources office shall notify the Controller’s Office (via the PPT document and standard form 674D) and the State Compensation Insurance Fund (via SCIF Form 68A) as soon as the campus anticipates expiration or termination of Industrial Disability Leave benefits as follows:

1.) In the event an employee has exhausted his/her IDL benefits and remains temporarily disabled, the employee shall be placed on Workers’ Compensation Temporary Disability, with or without supplementation. Supplementation may include sick leave, vacation and/or CTO credits.

2.) If the disabled employee is offered medically approved temporary light duty and refuses to accept such duty, the employee’s IDL benefits should be terminated. Furthermore, the employee would not be eligible to receive Workers’ Compensation Temporary Disability benefits.

3.) If at any time an employee receiving IDL benefits refuses to participate or cooperate in a reasonable vocational rehabilitation plan provided by the campus, s/he is no longer entitled to IDL payments. (Reference: Education Code Section 89529.09.) At this time, the employee shall be placed on Workers’ Compensation Temporary Disability payments, if otherwise eligible, with supplementation of applicable leave credits (sick leave, vacation, and/or CTO). The employee will have 15 calendar days to notify his/her department of the decision to NOT supplement the WCTD benefit with available leave credits.
If the employee has an adequate balance of leave credits available to supplement his/her Workers' Compensation Temporary Disability payments, s/he should be returned to active pay status. Standard form 674D should be completed as shown in the Disability Section of the State Controller's Payroll Procedures Manual.

4.) When a temporary employee's appointment expires while on IDL, the employee's IDL benefits will expire at the same time as the appointment and the employee will be separated. Following separation, if otherwise eligible, the employee may request Temporary Disability payments under Workers' Compensation. (Reference: RSA 76:79.)

**PAYMENTS - Industrial Disability Leave - Basic**

IDL provides that an eligible employee may receive up to 22 working days of full pay less an amount equal to his/her federal and state income tax and Social Security/Medicare taxes based on his/her exemptions in effect on the date of disability.

**Federal/State Tax and OASDI or Medicare**

Deductions for federal/state tax and OASDI or Medicare will NOT be made from IDL payments and IDL payments are not reported as Taxable Wages or Other Compensation on Form W-2. However, an employee's full gross will be reduced by the amount of federal and state tax and OASDI or Medicare to establish IDL reduced gross.

**Retirement**

Retirement contributions WILL BE deducted from all IDL payments. The deduction amount will be computed at the employee's current rate on the "full pay" amount and the "full pay" amount will be reported to PERS/STRS for full service credit. The state share will be computed in the same manner.

Full pay means the gross base salary the employee may earn (including shift differential payments) and subject to retirement contribution if s/he had not vacated the position. For example, for purposes of computing the IDL benefit payment for an employee injured while on Sabbatical Leave, full pay shall be the amount to which the employee's appropriate retirement system (PERS/STRS) retirement contribution is applied at the time of commencement of the Industrial Disability Leave.
Exemptions

The number of exemptions claimed by the employee on the Employee Action Request STD. 686 at the time a disability is incurred is one of several factors which will determine the size of IDL benefit payments. Employees should be encouraged to review the number of exemptions claimed on their Employee Action Request STD. 686 on a periodic basis. Employees should be informed of the effect the number of exemptions claimed will have on their IDL benefit payments should they incur a work-related disability.

Effect of Salary Adjustments

An employee’s IDL benefits shall be adjusted during his/her leave to reflect any changes (increases or decreases) in the gross base salary which would have occurred due to salary modifications. These include performance-based salary increases, service-based salary increases, general salary increases, special salary adjustments, or decreases due to demotions which s/he would have received had s/he not gone on an Industrial Disability Leave but remained on active employment. The goal of IDL is to maintain, as close as possible, the disabled employee’s take-home pay. IDL payment checks shall be issued by the State Controller’s Office.

If the industrial disability continues beyond 22 working days, the IDL payment will be adjusted to two-thirds of the employee’s gross monthly salary.

Probationary Period

A probationary employee who suffers a work-related injury and elects IDL coverage shall have his/her probationary period extended by the number of days on IDL. A probationary employee shall not gain permanent status in a classification while on IDL.

PAYMENTS - Industrial Disability Leave Benefits With Sick Leave Credit Supplementation

Both represented and nonrepresented employees shall be eligible to make application for supplementation of their Industrial Disability Leave benefits with accrued sick leave credits.

Employees whose disabilities are determined by the CSU to be work-related shall have a one-time opportunity to elect to receive Industrial Disability Leave benefits with or without supplementation of accrued sick leave credits.
up to regular salary or wages. Total benefit and supplementation shall not be in excess of an employee's regular salary or wage.

Before an employee may elect to supplement IDL with accrued sick leave credits, s/he must have sufficient credits to provide an IDL and supplementation amount equal to his/her regular daily salary or wage. The campus will stop supplementation when the combined IDL and supplementation amount is less than the employee's daily salary or wage. **Supplementation is limited to the use of sick leave accrued up to the date of the work-related injury or the first day of disability (which may be different than the date of injury) for which IDL with supplementation is sought, except as indicated under the Catastrophic Leave program.** If an employee is released to return to work but goes out on IDL at a later time for the same work-related injury, sick leave accrued during the time in work status may be used for supplementation purposes.

Supplementation shall be made only upon written notification to the campus by an eligible employee. The notification shall be given to a designated member or representative of CSU management no later than fifteen (15) calendar days from the mailing of the notice of benefit eligibility. The employee's election commences with the 23rd day on IDL. Supplementation shall continue until the employee has exhausted his/her pre-disability accrued sick leave credits or until the employee provides written notification to the campus s/he wishes to discontinue supplementation. The written notification must be provided at least 15 calendar days in advance of the supplementation termination date so as to permit the campus and the State Controller's Office sufficient time to process the necessary documents.

All payments received by an employee while on IDL shall be subject to mandatory and authorized voluntary deductions.

**ENHANCED INDUSTRIAL DISABILITY LEAVE (EIDL) - Unit 8**

Employees covered by the California State University and the Statewide University Police Association Agreement (Unit 8) are eligible for an Enhanced Industrial Disability Leave (EIDL) for disabilities occurring on or after October 1, 1995, under the following conditions:

1.) When an employee is disabled by injury or illness arising out of and in the course of his/her duties regardless of his/her period of service with the campus. The EIDL benefit for police officers is no longer limited to injuries received as a result of a criminal act of violence.

2.) The campus makes the determination of employee eligibility for the enhanced benefit. The campus may periodically review the employee's
condition by any means necessary to determine an employee’s eligibility for IIDL.

3.) The injury or illness meets the terms and conditions of the MOU and the policies and procedures outlined in this administrative guide.

4.) The injury or illness occurs between October 1, 1995 and June 30, 1998. The IIDL benefit expires on June 30, 1998, unless it is extended through the collective bargaining process.

The IIDL benefit will be equivalent to the injured employee’s net take home salary on the date of occurrence of the injury. IIDL eligibility and benefits may continue for no longer than one (1) year after the date of injury. For the purposes of this Section, “net salary” is defined as the amount of salary received after federal and state income taxes, Social Security/Medicare taxes, and the employee’s retirement contribution have been deducted from the gross salary.

The IIDL benefit does not apply to presumptive, stress-related disabilities, any psychiatric disability, or any physical disability arising from a psychiatric injury.

CATASTROPHIC LEAVE PROGRAM

The purpose of the Catastrophic Leave Program is to supplement any disability benefit for which the employee is eligible. Therefore, if the employee is eligible for IIDL, catastrophic leave should be used only to supplement that benefit. The employee should not be allowed to waive IIDL benefits at his/her option and still apply for catastrophic leave donations.

The use of catastrophic leave while on IIDL is problematic due to the fact that all leave credits (sick leave, vacation, CTO, and in some cases the personal holiday) must be exhausted before an employee may request participation in the Catastrophic Leave Program. If an employee is out of leave credits and requests and is deemed eligible to participate in the Catastrophic Leave Program, the employee’s sick and vacation leave credits should be used as accrued. Do not continue to process donated leave without exhausting the employee’s own leave credits. An employee’s participation in the Catastrophic Leave Program while on IIDL is the only exception for use of the injured employee’s vacation credits or use of the employee’s sick leave after the date of the injury or the first day of disability, if different. Please refer to Technical Letter HR/Benefits 5600 92-19 and collective bargaining agreements, if applicable.
FAMILY MEDICAL LEAVE

The Family Medical Leave (FML) entitlement, if available to the employee, should run concurrently with IDL benefits. Please refer to HR 94-11 and collective bargaining agreements, if applicable.

PAYMENTS - Deductions

IDL benefits are not considered a salary or wage; therefore, the State Controller's Office will not report IDL payments as earnings for tax purposes. However, for the IDL-Sick Leave and Catastrophic Leave Supplement programs, the supplement portion is reported as earnings.

Appendix C provides examples of computation of benefits and a sample form for campus use when making such estimates. The following transactional guidelines should be followed when making benefit estimates:

1.) The employee’s PERS/STRS contributions shall be deducted from the IDL benefit payment on the basis of his/her normal gross monthly salary.

2.) The State contribution to PERS/STRS shall be made on the basis of the disabled employee’s gross monthly salary rate.

3.) Voluntary deductions shall continue to be made unless canceled by the employee.

4.) The employee’s regular contribution to his/her health insurance premiums shall be deducted from his/her IDL benefit.

5.) The CSU shall continue to pay the employer’s contribution for the health, dental, vision, life and/or long term disability insurance premiums.

6.) While receiving IDL benefit payments, the employee shall continue to accrue sick leave, vacation, service credits, and salary modifications.

7.) Only court-ordered support garnishments will affect IDL benefit payments.

PAYMENTS - Adjustments to Reflect Salary Changes

The employee’s salary rate and the number of days and hours for which s/he would have been paid had the work-related disability not occurred shall be used to compute IDL payments at the time of disability in accordance with Section 89529.02(b) and 89529.03 of the Education Code. Thereafter, payments
shall be adjusted to reflect any salary adjustments which the employee would have received had s/he not incurred the disability.

In cases where the employee is on a variable work schedule, such as an intermittent employee who is a member of PERS/STRS, the employee’s salary rate and number of days and hours for which s/he would have been paid had the disability not occurred as well as his/her past work schedule shall be used by the campus to compute IDL benefit payments.

**PAYMENTS - Adjustment to Reflect Other Sources of Disability Benefits**

Education Code Section 89529.03 states that IDL benefit payments shall be adjusted to offset disability benefits, excluding those disability benefits payable from the State Teachers Retirement System, the employee may receive from other employer-subsidized programs, except that no adjustments will be made for benefits to which the employee’s family is entitled to a maximum of three-quarters of full pay. This allows an offset to IDL benefits only for other benefits which are paid for by the employer (e.g., Social Security payments) and does not offset against private income protection plans. Upon written notification by the employee that s/he is receiving other benefits, the campus shall adjust the employee’s IDL benefit to reflect this. If the employee does not notify his/her campus of other benefits s/he is receiving, this inaction would constitute grounds for removing the employee from the IDL program.

**PAYMENTS - Ten-Month and Ten-Twelve (10/12) or Eleven-Twelve (11/12) Pay Plan Employees**

When a permanent or probationary employee in a ten-month appointment class incurs a work-related disability while on the active payroll and selects IDL coverage, the employee shall be eligible for IDL benefit payments only for the period of active payroll status. If the employee is still disabled when s/he goes on inactive payroll status, the employee shall be transferred to Workers’ Compensation Temporary Disability for the two months of inactive payroll status. Upon the designated date of the employee’s return to active payroll status, if the employee’s disability continues, the employee is returned to IDL status for the balance of his/her IDL eligibility.

When an employee appointed on a temporary basis into a ten-month classification incurs a work-related disability while on the active payroll and selects IDL coverage, the employee shall be eligible for IDL benefit payments only for the period covered by the appointment. If the employee is still disabled at the end of the appointment, the employee is separated and placed on Workers’ Compensation Disability until SCP makes a decision that s/he is no longer eligible for benefits. NOTE: If the campus expressed an intent, in writing prior to a disabling injury, to reappoint the employee for a new ten-month period, the individual may be placed on active payroll status on the
designated date of the reappointment and returned to IDL status for the balance of his/her IDL eligibility.

Ten-Twelve and Eleven-Twelve Pay Plan employees will be continued on IDL for the duration of the benefit period. If, at the end of the benefit period the employee is still disabled, s/he shall be continued on Workers’ Compensation Temporary Disability until SCIF makes a decision that s/he is no longer eligible for benefits.

**PAYMENTS - Academic Year Employees**

**Semester and Quarter Systems**

When an employee appointed to an academic year class (usually covers the period from September through June for two consecutive semesters or three consecutive quarters) incurs a work-related disability during the academic year and selects IDL coverage, the employee shall not be eligible for IDL benefit payments during the vacation period (normally July and August) while receiving regular monthly salary payments. S/he may be eligible for medical and hospital costs reimbursement. If such an employee continues to be disabled following the start of a new appointment or continuing appointment for the new academic year, the employee shall be returned to IDL status. If s/he continues to be disabled beyond the vacation period but has not been reappointed for the new academic year, s/he may be eligible to receive Workers’ Compensation benefit payments.

When an employee appointed to an academic year class incurs a work-related disability during the vacation period while performing campus-related business, the employee, in all probability, would be receiving regular monthly salary payments during the vacation period and therefore shall not be eligible for concurrent IDL benefit payments. S/he may be eligible for medical and hospital costs reimbursement.

**Summer Session**

If an academic year appointment class faculty member incurs a work-related disability while employed during the Summer Session, s/he shall not be eligible for IDL but may qualify for Workers’ Compensation medical and hospital benefits under the terms and conditions of Continuing Education’s membership in the CSU Risk Pool. Since the disabled faculty member is not considered a “State” general fund employee while teaching during Summer Session, s/he is not eligible for the CSU IDL program.
Quarter System Year Round Operation (QSYRO)

When a faculty member in an academic year class employed on a QSYRO campus incurs a work-related disability while employed during an extra quarter for pay (typically the summer quarter), the faculty member shall not be eligible for IDL benefit payments concurrent with his/her salary payments during what normally would have been the vacation period.

When a faculty member in an academic year appointment class, employed on a campus operating on the quarter system, incurs a work-related disability while employed during a quarter in which s/he is banking salary payments for a future quarter off, the faculty member shall not be eligible for IDL benefit payments concurrent with his/her salary payments during what normally would have been the vacation period. Furthermore, there is no provision to bank IDL benefit payments to replace the lost earnings.

Employees in these two categories may be eligible for medical and hospital costs reimbursement. Only at such time when the faculty member is scheduled for a new appointment period and is not receiving concurrent salary payments is s/he eligible to select IDL benefits, should the disability continue into the new appointment period.

PAYMENTS - Partial Days of Absence

An employee receiving IDL benefits who is released by the physician to work only part-time shall be eligible to continue receiving IDL credit for the days on which s/he works. If the disabled employee works less than his/her scheduled work hours on a particular day, s/he shall receive wages for the hours actually worked and IDL payments for the balance of the workday. Partial days off work due to industrial disability shall be reported as full days of IDL. A partial day on IDL counts as a full day of IDL.

If an employee receiving IDL benefits is released by the physician to full-time employment and subsequently loses work time for doctor’s appointments, physical therapy etc., such absences shall be charged to the employee’s leave credits consistent with CSU policy on reporting of absences for non-exempt and exempt employees.

SELECTION OF PHYSICIAN

The campus shall exercise its right to control an injured employee’s course of treatment during the first 30 days following the injury if the employee has not provided the campus with the name of his/her personal physician in advance.
Pursuant to Labor Code Section 4600, an injured employee, after 30 days from the date the injury is reported, may be treated by a physician of his/her own choice at a facility of his/her own choice within a reasonable geographical area or one selected from a panel of physicians provided by the campus. (Please refer to Appendix D for legal requirements and procedures.) The campus retains the right to require periodic reevaluation by its own physician or facility as deemed necessary.

Pursuant to Labor Code Section 4603, the employer may request a change of physician by submitting a petition to the administrative director of the Division of Industrial Accidents.

ASSIGNMENT OF RESPONSIBILITIES - Please refer to Appendix E

REHABILITATION

Vocational rehabilitation is legally required on the part of the employer and employee (please refer to Appendix F). A brief description of the rehabilitation process is presented in Appendix G. NOTE: Professionals reviewing medical disposition should be versed in requirements of the Americans with Disabilities Act (ADA), as appropriate.

The State Compensation Insurance Fund and the campus shall determine the need for the disabled employee to undergo vocational rehabilitation. It shall be the ultimate responsibility of the State Compensation Insurance Fund to notify the disabled employee and his/her campus of such decision if it is decided to provide vocational rehabilitation to the employee.

If it is determined that the employee is medically unable to undergo or successfully complete his/her vocational rehabilitation program, s/he shall continue to receive Industrial Disability Leave benefits.

The campus should keep in mind that it should give foremost consideration to the right of return of the disabled employee back to his/her former position whenever possible.

RETURN TO EMPLOYMENT FOLLOWING REHABILITATION

The campus shall take at least one of the following actions at such time as the employee has successfully completed his/her vocational rehabilitation program initiated while under IDL:

1.) Restore the employee to his/her former position if able to perform such duties without danger to his/her health or safety or to that of others. If the employee is covered by the ADA, restore the employee to
his/her former position if s/he is able to perform the essential duties of the position with or without reasonable accommodation;

2.) Demote or transfer the employee to another position, if s/he is able to perform such duties. If the employee is covered by the ADA, demote or transfer the employee to another position if s/he is able to perform the essential duties of the position with or without reasonable accommodation;

3.) Place the employee on a training and development assignment in another line of work suitable to his/her disability with the intent to transfer at a later date.

4.) Initiate placement services for non-CSU employment.

The campus is responsible for making the final determination concerning the medical suitability of placement of the disabled employee who has completed his/her vocational rehabilitation program.

When an employee on IDL is no longer disabled, s/he shall be returned to his/her former position.

Upon the request of an employee who is dismissed, demoted, or reassigned pursuant to Sections 43403 and 43406, Title 5, the employee shall be reinstated to an appropriate vacant position in the same class, comparable class or in a lower related class if it is determined that the employee is no longer incapacitated for duty. (See Title 5, Section 43407.)

**APPEAL PROCESS**

When a disabled employee has complaints regarding IDL action taken by the campus or other State agencies, s/he may seek a remedy through the following appeal process:

1.) The employee shall first seek administrative remedy through the campus for complaints which can be resolved administratively. The employee should notify his/her Human Resources office of the complaint in writing within 30 days of its origin. If the matter is not resolved to the satisfaction of the employee, s/he may appeal to the appropriate appeal source set forth below.

2.) The Workers' Compensation Appeals Board of the Division of Industrial Accidents is the source of appeal for such matters as:

A.) Determinations on the CSU’s liability for provision of medical care.
B.) Determinations on whether disability was industrially caused.

C.) Determinations on eligibility for Workers' Compensation
Temporary Disability payments.

There are certain time limits during which appeals shall be filed (Labor Code Sections 5404 and 5410); therefore, it is advisable that such appeals be filed as soon as possible.
89529. (a) This article applies to employees of the trustees who are members of the Public Employees' Retirement System or the State Teachers' Retirement System in compensated employment on and after July 1, 1974.
(b) This article also applies to a participant in the optional retirement program pursuant to Chapter 3.5 (commencing with Section 86900), provided that he or she would otherwise be eligible to participate in the Public Employees' Retirement System except for the election to participate in the optional retirement program.
(c) This article does not apply to employees of the trustees who are included in the provisions of Article 6 (commencing with Section 4800) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

89529.01. If the provisions of this article are in conflict with the provisions of a memorandum of understanding reached pursuant to Chapter 12 (commencing with Section 25900) of Division 4 of Title 1 of the Government Code, the memorandum of understanding shall be controlling without further legislative action, except that if the provisions of a memorandum of understanding require the expenditure of funds, the provisions shall not become effective unless approved by the Legislature in the annual Budget Act.

89529.02. As used in this article:
(a) "Industrial disability leave" means temporary disability as defined in Divisions 4 (commencing with Section 3200) and 12.5 (commencing with Section 5100) of the Labor Code and includes any period in which the disability is permanent and stationary and the disabled employee is undergoing vocational rehabilitation.
(b) "Full pay" means the gross base pay earnable by the employee and subject to retirement contribution if he or she had not vacated his or her position.

89529.03. When an employee is temporarily disabled by illness or injury arising out of and in the course of state employment, he or she shall become entitled, regardless of his or her period of service, to receive industrial disability leave and payments, in lieu of workers' compensation temporary disability payments and payment under Section 89527, for a period not exceeding 52 weeks within two years from the first day of disability. The payments shall be in the amount of the employee's full pay less withholding based on his or her exemptions in effect on the date of his or her disability for federal income taxes, state income taxes, and social security taxes not to exceed 22 working days of disability subject to Section 89529.08. Thereafter, the payment shall be two-thirds of full pay. Payments shall be additionally adjusted to offset disability benefits, excluding those disability benefits payable from State Teachers' Retirement System, the employee may receive from other
employer-subsidized programs, except that no adjustment will be made for benefits to which the employee's family is entitled up to a maximum of three-quarters of full pay. Contributions to the Public Employees' Retirement System or the State Teachers' Retirement System shall be deducted in the amount based on full pay. Discretionary deductions of the employee including those for coverage under a state health benefits plan in which the employee is enrolled shall continue to be deducted unless canceled by the employee. State employer contributions to the Public Employees' Retirement System and state employer normal retirement contributions to the State Teachers' Retirement System shall be made on the basis of full pay and state contributions pursuant to Sections 22825.1 and 22826 of the Government Code because of the employee's enrollment in a health benefits plan shall continue.

89529.04. An employee who is receiving industrial disability leave benefits shall continue to receive all employee benefits which he or she would have received had he or she not incurred disability.

89529.05. The disabled employee shall not receive temporary disability indemnity or sick leave or annual leave with pay for any period for which he or she receives industrial disability leave, however, he or she may elect to waive the provisions of this article and to receive disability indemnity pursuant to Divisions 4 (commencing with Section 3200) and 4.5 (commencing with Section 6100) of the Labor Code and to receive payments under Section 89527 in lieu of the benefits provided in this article. If the amount of the employee's benefits payable under this article is less than the amount he or she would receive under Divisions 4 (commencing with Section 3200) and 4.5 (commencing with Section 6100) of the Labor Code, the employee shall be deemed to have rejected the benefits of this article and shall be paid benefits pursuant to Divisions 4 (commencing with Section 3200) and 4.5 (commencing with Section 6100) of the Labor Code.

89529.06. Division 4.7 (commencing with Section 6200) of the Labor Code shall not apply to employees to which this article applies.

89529.07. If an employee continues to be temporarily disabled after termination of benefits under this article, he or she shall be entitled to the benefits provided by Division 4 (commencing with Section 3200) and 4.5 (commencing with Section 6100) of the Labor Code and to payments under Section 89527.

89529.08. [a] If an illness or injury causes temporary disability, the employee shall be placed on industrial disability leave on the fourth calendar day after the injured employee leaves work as a result of the illness or injury, except that in case the injury causes disability of more than 14 days or necessitates hospitalization, the employee shall be placed on industrial disability leave from the first day he or she leaves work or is hospitalized as a result of the injury.
(b) Notwithstanding subdivision (a), the disability payment shall be made from the first day the injured employee leaves work as a result of the injury, if the injury is the result of a criminal act of violence against the employee.

§5529.09. Payments shall be contingent on the complete medical certification of the illness or injury including diagnosis and any prognosis of recovery. Furthermore, payments shall be contingent on the employee's agreement to cooperate and participate in a reasonable and appropriate vocational rehabilitation plan when furnished by the state subject to appropriate medical approval as determined by the trustees.

§5529.10. The trustees or its designee shall adopt any rules and regulations necessary for the administration of this article for its employees.

§5529.11. (a) This article shall be effective upon the adoption of applicable rules and regulations, but not later than January 1, 1975.

(b) The enactment of this article at the 1987-88 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the existing law.
INDUSTRIAL DISABILITY BENEFITS INFORMATION

We are sorry to hear about your misfortune and sincerely hope that you make a full recovery and return to work soon. As a CSU Employee, you are entitled to certain disability benefits as below.

You have the choice of receiving Industrial Disability Leave payments or Workers’ Compensation Temporary Disability payments with the option of Supplementation of Applicable Leave Credits (Full or Partial) at this time. Review the information carefully and wait for your campus representative to contact you within 15 days of the date of your injury. Call your personnel office at this time, your campus representative will help explain what your benefits are.

**DESCRIPTION OF BENEFITS AVAILABLE**

<table>
<thead>
<tr>
<th>Questions About Your Benefits</th>
<th>Workers’ Compensation Temporary Disability</th>
<th>Workers’ Compensation Temporary Disability with Supplementation of Applicable Leave Credits (Full or Partial)</th>
<th>Industrial Disability Leave</th>
<th>Industrial Disability Leave with Sick Leave Supplementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is eligible for benefit payments?</td>
<td>All CSU Employees.</td>
<td>All CSU employees with Available Leave Credits.</td>
<td>PERS &amp; STRS members except for those included in Labor Code Section 4800.</td>
<td>PERS &amp; STRS members except for those included in Labor Code Section 4800.</td>
</tr>
<tr>
<td>How much will my benefit be?</td>
<td>Amount varies; up to $70 per day.</td>
<td>Amount varies; up to $70 per day plus Supplementation Leave Credits up to full pay.</td>
<td>Amount varies; full net pay for 22 working days; 2/3 gross pay thereafter less discretionary deductions.</td>
<td>Amount varies; may supplement to full net pay for as long as leave credits last.</td>
</tr>
<tr>
<td>How are my medical bills to be paid?</td>
<td>The State Compensation Insurance Fund pays for all eligible hospital, medical and surgical expenses.</td>
<td>The State Compensation Insurance Fund pays for all eligible hospital, medical and surgical expenses.</td>
<td>The State Compensation Insurance Fund pays for all eligible hospital, medical, and surgical expenses.</td>
<td>The State Compensation Insurance Fund pays for all eligible hospital, medical, and surgical expenses.</td>
</tr>
<tr>
<td>How long will benefits be provided?</td>
<td>Until able to return to work (240 weeks within 5 years from date of injury maximum).</td>
<td>Until able to return to work (240 weeks within 5 years from date of injury maximum).</td>
<td>Until able to return to work (52 weeks within 2 years from first date of disability). After expiration, you may be eligible for Workers’ Compensation Temporary Disability.</td>
<td>Until able to return to work (52 weeks within 2 years from first date of disability). After expiration, you may be eligible for Workers’ Compensation Temporary Disability.</td>
</tr>
<tr>
<td>Does the CSU contribution to your health insurance premium continue?</td>
<td>No. You must pay full premium directly to carrier to maintain coverage.</td>
<td>CSU contribution continues.</td>
<td>CSU contribution continues.</td>
<td>CSU contribution continues.</td>
</tr>
<tr>
<td>Do you continue to receive service credit for vacation, sick leave and seniority?</td>
<td>You continue to receive full credit.</td>
<td>You continue to receive full credit.</td>
<td>You continue to receive full credit.</td>
<td>You continue to receive full credit.</td>
</tr>
<tr>
<td>Do you continue to make PERS contribution?</td>
<td>Your option. If you wish to continue membership you must pay directly to PERS.</td>
<td>You make PERS contributions on the leave credit portion of pay. You may pay remainder directly to PERS.</td>
<td>You continue to make your full PERS contribution.</td>
<td>You continue to make your full PERS contribution.</td>
</tr>
<tr>
<td>How will disability benefits from other sources affect my benefits?</td>
<td>No effect.</td>
<td>No effect.</td>
<td>Your benefit may be reduced if you receive other benefits.</td>
<td>Your benefit may be reduced if you receive other benefits.</td>
</tr>
<tr>
<td>Is vocational rehabilitation available?</td>
<td>It will be provided if necessary at your discretion.</td>
<td>It will be provided if necessary at your discretion.</td>
<td>You must participate in vocational rehabilitation if it is deemed necessary.</td>
<td>You must participate in vocational rehabilitation if it is deemed necessary.</td>
</tr>
</tbody>
</table>

*Please refer to Code for most recent amount.*
### Industrial Disability Leave/Workers' Compensation Temporary Disability Comparison Estimate

<table>
<thead>
<tr>
<th>Name:</th>
<th>SSN:</th>
<th>Date of Injury:</th>
<th>Date:</th>
</tr>
</thead>
</table>

#### LEAVE CREDIT AVAILABLE AS OF THE DATE OF INJURY:

<table>
<thead>
<tr>
<th>Sick Leave</th>
<th>Direct Deposit: Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacation</td>
<td>Tax Status:</td>
<td></td>
</tr>
<tr>
<td>Overtime</td>
<td>Federal:</td>
<td></td>
</tr>
<tr>
<td>Personal Holiday</td>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Holiday Credits</td>
<td>Additional $</td>
<td>Additional $</td>
</tr>
</tbody>
</table>

**Total Hours of Leave Credit Available:**

I. Industrial Disability Leave (IDL) - Provides a benefit of up to 22 days at "Full Pay" which is the employee's gross salary less the amount that is normally deducted for mandatory deductions (e.g., Federal and State taxes). After 22 days, the employee is paid at 2/3 rate of their gross pay. The following computations establish monthly net benefit under each option.

#### First 22 days:

<table>
<thead>
<tr>
<th></th>
<th>Gross Monthly Salary</th>
<th>2/3 Gross Monthly Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ ___________</td>
<td>___________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Federal Tax Withheld</th>
<th>State Tax Withheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Less</td>
<td>__________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Federal/Medicare</th>
<th>Retirement Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Total ______________</td>
<td>______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Deductions</th>
<th>Mandatory Deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Plus</td>
<td>______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Est. Monthly Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>______________</td>
</tr>
</tbody>
</table>

#### After 22 days:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Monthly Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Total</td>
<td>______________</td>
</tr>
</tbody>
</table>

Sick Leave Credit needed for a full month of supplementation:

- @ 168 hrs/month = 56 hours
- @ 176 hrs/month = 59 hours

II. Workers' Compensation (TD) - The benefit is determined by the State Compensation Insurance Fund

1. $ ___________ Monthly Temporary Disability (TD) Payment
2. Less ________________ Retirement Contribution (Optional for TD without supplementation)
3. ________________ Health Insurance (Total premium paid by employee - no State contribution)
4. ________________ Estimate Monthly Net Benefit

#### Workers' Compensation with Supplement

5. ________________ Monthly Net Benefit from #4 above needed for a full month of supplementation:
6. Plus ________________ Supplementation

7. ________________ Federal Tax Withheld on Supplemental Income
8. ________________ State Tax Withheld on Supplemental Income
9. ________________ FICA/Medicare on Supplemental Income
10. ________________ Voluntary Deductions

8. ________________ Est. Monthly Net Benefit
My industrial disability benefits and program options have been explained to me. I hereby select the following:

_________ Industrial Disability Leave - Basic
_________ Industrial Disability Leave with Sick Leave Supplementation
_________ Industrial Disability Leave - Enhanced Plan (Unit II only)
_________ Workers' Compensation Temporary Disability
_________ Workers' Compensation Temporary Disability with Supplementation

I understand that I must keep my Payroll Office informed of any industrial disability benefits I receive from other programs. I agree to participate in vocational rehabilitation when furnished by the California State University or any of its designated organizations.

_________________________ ______________________
Employee Signature

_________________________ ______________________
Campus Representative Signature

Date
Date
§ 9770.6 Reimbursement of Costs to the Administrative Director; Obligation to Pay Share of Administrative Expenses.

(a) Each organization certified under this article shall pay to the administrative director an amount as estimated by the administrative director for the ensuing fiscal year, as a reimbursement of a share of all costs and expenses, including maintenance of its records, maintenance and dissemination of information, and other expenses reasonably incurred in the administration of this article, and not otherwise recovered by the administrative director under this article, or from the Workers' Compensation Managed Care Fund. The amount shall be assessed equally on or before April 15 and may be paid to the Workers' Compensation Managed Care Fund in two equal installments. The first installment shall be paid on or before July 1 of each year and the second installment shall be paid on or before December 15 of each year.

(1) Annual Assessment: The assessment shall be calculated on the basis of the number of enrollees in each HCO. Each HCO will be assessed a sum equivalent to 1.00% per enrollee, based on the number of enrollees enrolled in the HCO on 12/31 of the prior calendar year.

(2) Enrollment Requirements: Ninety days prior to the date on which the percentage fund loan repayment is due, the DWC will assess each certified HCO's sum to represent its share of the monies required for DWC to reimburse its general fund loan. The loan repayment assessment shall be calculated as follows:

\[
\text{Outstanding loan balance} \times \text{(number of enrollees enrolled in HCO)} = \text{amount per enrollee in HCO.}
\]

(b) Non-profit entities enrolled in the program to comply will be charged based on the actual cost for performing the audits. The invoices will be sent within sixty days of the completion of the audit and shall be paid within thirty calendar days after the billing date.

(c) In case the reimbursement payment, or other fees authorized by this section are not paid, including interest, reasonably incurred in the administration of this article, the DWC may take the necessary action to enforce compliance.

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11165 (Reg. No. 95, No. 10).

§ 9770.8 Copies of Documents.

Pursuant to Section 1028, any request for copies of documents must include payment of fees by check or money order paid to the Workers' Compensation Managed Care Fund.

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11165 (Reg. No. 95, No. 10).

§ 9770.9 Late Payment.

Failure to pay fees and assessments within sixty days after the date due pursuant to this section shall be considered an additional fee to be paid pursuant to this section. Each such additional fee shall be paid by the employer at the rate of one dollar per day for each day past the due date, up to a maximum of forty-five dollars, whichever is greater. In addition, after sixty days a late fee of ten percent per year shall be assessed on any outstanding amount. In addition, the administrative director may suspend or revoke certificates of HCO's that fail to pay fees and assessments in a timely manner.

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11165 (Reg. No. 95, No. 10).

§ 9780.1 Employees Selection of Personal Physician.

If an employee desires to be treated by a "personal physician" selected pursuant to Labor Code Section 406e, the employee shall notify the employer in writing. The notice must be submitted to the employer not later than thirty days after the date of the injury or illness. The employer shall have thirty days from the date of the notice to provide the employee with a list of eligible personal physicians. The employee shall then select a personal physician from the list provided by the employer. The employer shall not be liable for the selection of the personal physician, and the employee is not required to accept the personal physician selected by the employer.

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11165 (Reg. No. 95, No. 10).
Appendix D

§ 9760.2

Barclays California Code of Regulations

Page 2

No text content provided for this page.
notify the employer if the selected physician or facility promptly gives a written report to the employer. If the employer does not receive the report within 7 days, the employer may request that the employee receive the report. If the employee omits to report the accident, the employee shall notify the employer of the occurrence of the accident or illness within 7 days.

In addition, the employee shall promptly notify the employer if the employee receives any medical treatment for the accident or illness or if the employee is employed by a physician who is a licensed physician or physician's assistant for the purpose of rendering or providing medical treatment. If the employer is not notified within 7 days, the employer may request that the employee receive the report. If the employee omits to report the accident, the employee shall notify the employer of the occurrence of the accident or illness within 7 days.

In addition, the employee shall promptly notify the employer if the employee receives any medical treatment for the accident or illness or if the employee is employed by a physician who is a licensed physician or physician's assistant for the purpose of rendering or providing medical treatment. If the employer is not notified within 7 days, the employer may request that the employee receive the report. If the employee omits to report the accident, the employee shall notify the employer of the occurrence of the accident or illness within 7 days.

In addition, the employee shall promptly notify the employer if the employee receives any medical treatment for the accident or illness or if the employee is employed by a physician who is a licensed physician or physician's assistant for the purpose of rendering or providing medical treatment. If the employer is not notified within 7 days, the employer may request that the employee receive the report. If the employee omits to report the accident, the employee shall notify the employer of the occurrence of the accident or illness within 7 days.
the employee shall remain the primary treating physician. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975.

(6) The employee's treating physician, or a physician designated by the patient, shall make periodic examinations of the employee. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975 if the employee agrees to be treated by such a physician.

(7) The employee's treating physician shall make periodic examinations of the employee. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975 if the employee agrees to be treated by such a physician.

(8) The employee's treating physician shall make periodic examinations of the employee. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975 if the employee agrees to be treated by such a physician.

(9) The employee's treating physician shall make periodic examinations of the employee. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975 if the employee agrees to be treated by such a physician.

(10) The employee's treating physician shall make periodic examinations of the employee. If it is determined that there is further need for care, the employee shall be advised to consult with a physician of the employee's choosing in accordance with subdivision (b) of Section 7975 if the employee agrees to be treated by such a physician.
Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

§ 9790. Authority.
The rules and regulations contained in this Article are adopted pursuant to the authority contained in Sections 133, 4003.5, 3071.1 and 5307.3 of the California Labor Code.

Notwithstanding all other provisions of this Article, the provisions hereof shall be construed to mean, and to have effect, as follows:

(a) "Composite Factor" means the factor calculated by the administrative director for each health facility by adding the prospective operating costs and the prospective capital costs for the health facility, excluding the DRG weight and any applicable outlier payment, as determined by the federal Health Care Financing Administration for the purpose of determining reimbursement under Medicare.

(b) "DRG weight" means the weighting factor for a diagnosis-related group assigned by the Health Care Financing Administration for the purpose of determining reimbursement under Medicare.

(c) "Revised DRG weight" means the product of the DRG weight multiplied by the ratio set forth in subsection (c)(1) for all specified DRGs to reflect the different resource usage between the workers' compensation population and the Medicare population.

The rules to be applied to the DRG weights are as follows:
ASSIGNMENT OF RESPONSIBILITIES

When an employee becomes industrially disabled, the parties involved shall assume the following responsibilities: (Please see Appendix H for an employee IDI claim process flow chart.)

Injured Employee

After sustaining a work-related injury or illness, immediately reports it to his/her supervisor and requests an employee claim form but not later than 24 hours after the injury becomes known.

Supervisor of Injured Employee or Appropriate Campus Administrator

1.) Arranges for, or administers, first aid; arranges for transportation to and treatment by a physician, if necessary.

2.) Prepares "Supervisor's Injury Prevention Report," Standard Form 620. Provides employee claim form #DWC3301 to employee within 24 hours of notification of injury or illness. (If unsure of the work-related status of the injury, check box 2.6 of Form 620 - "From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with CSU employment.")

3.) If the injury causes death or a serious injury or illness, a telephone report of the incident shall be made immediately to the appropriate office of the Department of Industrial Relations (Labor Code Section 6409.1).

Appropriate Campus Administrator

Prepares "Employer's Report of Occupational Injury or Illness," State Compensation Insurance Fund (SCIF) Form 3067 (if the employee was hospitalized or absent from the job one or more work days because of that injury), and mails it to the SCIF Adjusting Office serving the campus that initiated the injury report along with the employee claim form DWC1 3301. Do not count the day of injury as a day of absence. Form 3067 must be submitted to SCIF no later than 5 days after notification of the employee's work injury or death.

Within five (5) working days from receiving notice of knowledge of a work related injury, the campus administrator notifies the injured employee or his/her dependents of the benefits to which the employee or dependents may be entitled.
State Compensation Insurance Fund (SCIF) Adjusting Office

1.) Verifies:
   A.) Campus/departmental liability for Workers’ Compensation benefits;
   B.) That the injured employee is temporarily disabled (a requirement for IDL benefits).

2.) Sends SCIF Form 3290, “Temporary Disability Verification of State Employee,” to the campus IDL Administrator noting:
   A.) An authorized period of temporary disability;
   B.) The daily calendar Temporary Disability (TD) rate. (Needed by the Personnel Office, and the injured employee, to compare with the daily IDL rate. If the IDL rate is less than the TD, IDL must be waived.)

3.) Notifies the injured employee (usually 10-15 days after receiving the injury report, SCIF Form 3067) of the general benefits due under TD and IDL.
   Sends SCIF Form C-68, “Notice About Your Workers’ Compensation Benefits” to the disabled employee.

4.) Sends the Workers’ Compensation/IDL Administrator a copy of SCIF Form C-68.

Campus IDL Administrator/Return to Work Coordinator

Following receipt of the campus IDL Administrator’s copy of the SCIF Form C-68, arranges for the counseling of the disabled employee within 15 days of the date on the SCIF Form C-68 in order to:

1.) Explain the benefit options available under both TD and IDL through a telephone call or a personal visit to the employee.

2.) Assist the employee to select the best benefit, TD or IDL, by answering his/her questions. Do not advise on which benefits to select.
Disabled Employee

Selects his/her choice of benefits, either TD with or without supplementation of available leave credits (sick leave, vacation, and/or CTO), or IDL with or without supplementation of sick leave credits and mails "Disability Benefit Selection Notice #619" to the campus IDL Administrator as notification of benefit selection.

Note: The employee has 15 days from the date typed on his/her copy of Form 619 to notify the Human Resources Office of the benefits selected via the above selection notice. If no notification is made, the campus is required to provide IDL benefits (provided IDL benefits are in fact greater than TD benefits).

If the disabled employee is incapable of making decisions for himself/herself, request a guardian/trustee be appointed through SCIF by the Workers' Compensation Appeals Board.

Appropriate Campus Administration

1.) Notifies the appropriate SCIF Adjusting Office using SCIF Form 68-A, "Supplemental Information Regarding Work Disability," of any significant factors affecting the disabled employee's benefits. Such factors include:

A.) Employee is not a PERS or STRS member and is not eligible for IDL.

B.) Employee has initially chosen TD rather than IDL (Note: No notification necessary if employee chooses IDL).

C.) IDL rate is below TD rate.

D.) Employee initially chooses Workers' Compensation Temporary Disability payment but changes to IDL after 90 days or vice versa.

E.) Employee refused appropriate rehabilitation plan and loses his/her eligibility for IDL and must be placed on Workers' Compensation Temporary Disability payments.

F.) Employee has exhausted his/her IDL benefits and must be placed on Workers' Compensation Temporary Disability benefits if he/she is still temporarily disabled.
2.) Maintains complete and accurate records of calendar days absent while the employee is on leave. Each new independent disability must be recorded separately with its own 52 week period. However, reoccurrence of old disabilities do not entitle the disabled employee to a new 52 week IDL eligibility period.

3.) Notifies State Controller via Standard Form 674D or PPT of:

   A.) The number of calendar days of IDL within each pay period;

   B.) The number of days the disabled employee worked or would have worked in each pay period had he/she not been disabled;

   C.) Any changes in the salary rate of the employee on IDL; and

   D.) Any change in the employee's choice of benefits after 90 days of disability.
§ 10121. End of Term of Office of Public Officers and Employees.

For purposes of Labor Code Section 5400.5, the term of office for purposes of this section expires on the specified day unless otherwise provided by law.

(a) The term of office for a public officer or employee is the term of office as specified in the pertinent public officer or employee code section.

(b) The term of office for a public officer or employee is the term of office as specified in the pertinent public officer or employee code section.

(c) An order of the court, issued after the term of office has expired, is void.

(d) An order of the court, issued after the term of office has expired, is void.

(e) An order of the court, issued after the term of office has expired, is void.

(f) An order of the court, issued after the term of office has expired, is void.

§ 10122. Reporting Requirements.

(1) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(2) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(3) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(4) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

§ 10123. Duties of the Public Officer or Employee.

(1) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(2) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(3) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(4) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(5) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

§ 10124. Duties of the Public Officer or Employee.

(1) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(2) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(3) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(4) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

§ 10125. Duties of the Public Officer or Employee.

(1) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(2) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(3) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(4) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(5) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

§ 10126. Duties of the Public Officer or Employee.

(1) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(2) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(3) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(4) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.

(5) Each public officer or employee shall file a report of financial interests with the designated agency as required by law.
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10124. Identification of Medical Eligibility.

(a) For Injuries Occurring on or after 1/1/90 through 12/31/92.

Within 25 days of receipt of the assignment required by subdivision (b) of Labor Code section 4656, the qualified rehabilitation representative shall:

(1) Meet with the employee to explain the services available to assist the employee in returning to work.

(2) Select an appropriate medical facility and/or physician for the employee.

(b) For Injuries Occurring on or after 1/1/94.

Within 30 days of the employee's return to work, the claims administrator shall:

(1) Provide the employee with a job description, which includes the employee's job title and the information from the employer on the employee's duties.

(2) Provide the employee with a job placement plan, which includes a description of the injured employee's duties.

(3) Provide the employee with a referral to a medical facility for further evaluation.

(4) Provide the employee with a referral to a vocational rehabilitation provider for assistance in returning to work.

10125. Unrepresented Employees.

(a) For Injuries Occurring on or after 1/1/90.

If an injured employee is not represented by an attorney, the employee shall:

(1) Provide the claims administrator with a written statement of the employee's request for vocational rehabilitation services.

(2) Provide the claims administrator with a list of potential vocational rehabilitation providers.

(b) For Injuries Occurring on or after 1/1/94.

If an injured employee is not represented by an attorney, the employee shall:

(1) Provide the claims administrator with a written statement of the employee's request for vocational rehabilitation services.

(2) Provide the claims administrator with a list of potential vocational rehabilitation providers.

10126. Referral to Rehabilitation Providers.

(a) For Injuries Occurring on or after 1/1/90.

If an injured employee is not represented by an attorney, the claims administrator shall:

(1) Provide the employee with a list of potential vocational rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.

(b) For Injuries Occurring on or after 1/1/94.

If an injured employee is not represented by an attorney, the claims administrator shall:

(1) Provide the employee with a list of potential vocational rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.

10127. Requirements for Rehabilitation Providers.

(a) For Injuries Occurring on or after 1/1/90.

If the claims administrator determines that a rehabilitation provider meets the requirements for vocational rehabilitation services, the claims administrator shall:

(1) Provide the employee with a list of potential rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.

(b) For Injuries Occurring on or after 1/1/94.

If the claims administrator determines that a rehabilitation provider meets the requirements for vocational rehabilitation services, the claims administrator shall:

(1) Provide the employee with a list of potential rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.

10128. Vocational Rehabilitation Services.

(a) For Injuries Occurring on or after 1/1/90.

If the claims administrator determines that a rehabilitation provider meets the requirements for vocational rehabilitation services, the claims administrator shall:

(1) Provide the employee with a list of potential rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.

(b) For Injuries Occurring on or after 1/1/94.

If the claims administrator determines that a rehabilitation provider meets the requirements for vocational rehabilitation services, the claims administrator shall:

(1) Provide the employee with a list of potential rehabilitation providers.

(2) Provide the employee with a written statement of the employee's request for vocational rehabilitation services.
§ 10124

BARCLAYS CALIFORNIA CODE OF REGULATIONS

Appendix F

Page 3

Title 8

History
1. Change without regulatory effect renumbering and amending former section 10124 in section 10124.1 and former section 10124.1 to renumber 10124 (and 1-22-91 pursuant to section 100), Title 7, California Code of Regulations. (Reg. 91, No. 10.) For prior history, see Register 90, No. 4.
2. Technical correction of printing error making section 10124 (Register 91, No. 31).

(The next page is 1261.)
§ 1012.6. Vocational Rehabilitation; Plans and Offers of Modified or Alternate Work.

(a) For injuries occurring prior to 1/1/94:
(1) Injuries occurring prior to 1/1/94, the claim administrator shall either:
   (a) Submit a Vocational Rehabilitation Plan to the Rehabilitation Unit, in accordance with the provisions of Labor Code Section 4664(a)(5), or
   (b) Unless the injured worker and employer agree to a vocational rehabilitation plan, the claim administrator shall submit a written plan for the approval of the Rehabilitation Unit.

(b) For injuries occurring on or after 1/1/94:
(1) Injuries occurring on or after 1/1/94, the injured worker may receive a Vocational Rehabilitation Plan, unless the injured worker agrees to a Vocational Rehabilitation Plan, in accordance with the provisions of Labor Code Section 4664(a)(5).

(2) A Vocational Rehabilitation Plan shall be submitted to the Rehabilitation Unit, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.1. Vocational Rehabilitation Maintenance Allowance.

(a) Vocational Rehabilitation Maintenance Allowance (VRMA) payments shall be made every 14 days as the day designated by the first payment.

(b) If the injured worker fails to cooperate with the vocational rehabilitation services, as requested by the claim administrator, the claim administrator may deem the injured worker to be non-cooperative and terminate the vocational rehabilitation services.

(c) The claim administrator may terminate the vocational rehabilitation services if the injured worker fails to participate in the vocational rehabilitation services for 14 consecutive days.

§ 1012.6.2. Maximum Vocational Rehabilitation Expenditures for Injuries Occurring On or After 1/1/94.

The maximum expenditure for maintaining, existing, maintaining, or providing rehabilitation services shall be limited to 30% of the injured worker's average weekly wage for the 52 weeks prior to the injury.

§ 1012.6.3. Notice to worker of termination of rehabilitation services.

The claim administrator shall notify the injured worker of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.4. Notice to employer of termination of rehabilitation services.

The claim administrator shall notify the employer of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.5. Notice to Rehabilitation Unit of termination of rehabilitation services.

The claim administrator shall notify the Rehabilitation Unit of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.6. Notice to workers' compensation provider of termination of rehabilitation services.

The claim administrator shall notify the workers' compensation provider of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.7. Notice to workers' compensation provider of the termination of rehabilitation services.

The claim administrator shall notify the workers' compensation provider of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.8. Notice to workers' compensation provider of the termination of rehabilitation services.

The claim administrator shall notify the workers' compensation provider of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.9. Notice to workers' compensation provider of the termination of rehabilitation services.

The claim administrator shall notify the workers' compensation provider of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).

§ 1012.6.10. Notice to workers' compensation provider of the termination of rehabilitation services.

The claim administrator shall notify the workers' compensation provider of the termination of vocational rehabilitation services, in accordance with the provisions of Labor Code Section 4664(a)(5).
101271. Dispute Resolution.
When there is a dispute regarding the provision of occupational rehabilitation services, either the employee or the claim administrator may request the Rehabilitation Unit to resolve the dispute. All requests for dispute resolution shall be submitted as follows:
(a) If the request for dispute resolution results from an employee's objection to the claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(b) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(c) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(d) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(e) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(f) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(g) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(h) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(i) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(j) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(k) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(l) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(m) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(n) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(o) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(p) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(q) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(r) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(s) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(t) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(u) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(v) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(w) If a dispute involves an employee's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(x) If a dispute involves a claim administrator's determination to cease the provision of occupational rehabilitation services and terminate the claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(y) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to withhold maintenance payment pursuant to section 106, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.
(z) If the request for dispute resolution results from an employee's objection to a claim administrator's determination to terminate a claim for occupational rehabilitation services pursuant to section 104, the employee shall send the request in writing to the Rehabilitation Unit in accordance with procedures set forth in this regulation or in a written agreement between the claim administrator and the employee.

§ 10127. Conference(s).
(a) Upon receipt of a "Request for Dispute Resolution," DWC Form 121-014, the Rehabilitation Unit shall conduct a conference if a formal conference is necessary. Notice shall be served by the Rehabilitation Unit on all parties, identifying the date, time, and location of any conference. Where the request is initiated by an unreimbursed employee, the Rehabilitation Unit and an Information & Assistance Officer may assist the employee in completing and serving the form.
(b) Rehabilitation Unit Conference shall be held on the date and time scheduled. Any party unable to attend the conference may request a change in locations and times. Notice of the time and locations of any conference and the right to request a change in locations and times shall be provided to the other parties.
(c) If the date is rescheduled, the parties concerned shall be notified by the Rehabilitation Unit within five business days of the new date. Notice of the new date and the right to request further changes in locations and times shall be provided to the other parties.
(d) Change in the locations and times of any conference shall be made only by written consent of all parties concerned, or in accordance with the rules of the Rehabilitation Unit.
(e) Change without reasonable cause shall be subject to the provisions of this section and the rules of the Rehabilitation Unit.

§ 10127.1. Independent Vocational Evaluations.
(a) The Rehabilitation Unit Head must maintain a list of Qualified Rehabilitation Representatives (QRRs) who meet the requirements of an Independent Vocational Evaluator (IVE) pursuant to Labor Code section 5665.6. A QRR who asks the qualifications specified in Labor Code section 5665.6 may apply to be added to the list of QRRs and may be considered for appointment to the Rehabilitation Unit.
(b) The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party. The parties shall be notified of the appointment of an IVE to each party.
claims administrator is unable to agree to a continuance of the deferral of an interest on a fishing license, the fishing license is to be terminated, and the fish will be released back into the wild.

10.120. Request for Reinstatement of Vocationally Rehabilitative Services

(a) A request for reinstatement of vocationally rehabilitative services following an interruption or deferral shall be made in accordance with Labor Code sections 5644 et seq. and 5645.5.

(b) The request must be made in writing to the claims administrator, and must include a statement of the reason for the request.

10.131. Termination of Vocationally Rehabilitative Services

(a) When the claims administrator has determined that a claim has been paid in full, the claim shall be closed.

(b) When a claim is closed, the claims administrator shall provide a notice of termination to the claimant.

(c) The notice must be sent within 30 days of the date the claims administrator closes the claim.

(d) The notice must include the following information:

1. The date the claim was filed.
2. The date the claim was determined to be a claim.
3. The date the claim was paid in full.
4. The amount paid in full.
5. The claim number.
6. The claims administrator's name and contact information.

(e) A copy of the notice must be sent to the insurer and any other parties as required by law.
employees with dates of injury on or after 1/1/90 to the emergency Rehabilitation Unit district office with copies to all parties. The request shall be accompanied with the signed "Statement of Decline of Rehabilitation Benefits," DWC Form RU-107, and a copy of notice of potential eligibility for employees with dates of injury prior to 1/1/90. For employees with dates of injury on or after 1/1/90, the "Employee Statement of Declination of Vocational Rehabilitation Services," DWC Form RU-107, and a copy of notice of potential eligibility shall be submitted.


HISTORY
1. Change without regulatory effect enacting and amending former section 60123 (in effect 6/26/17) to sections 10131.1 through 10131.25 (enacted 1/28/19) and former section 10131 (in effect 12/27/18) to section 10131.2 (enacted 5/30/19) (Register 91, No. 20). For prior history, see Register 90, No. 4.


3. Change without regulatory effect enacting and amending former section 60125 (in effect 12/27/18) to section 10131.2 (enacted 5/30/19) (Register 90, No. 11).

4. Amendment dated 12/27/18, effective 12/27/18. Submitted to OAL, forgoing only pursuant to Government Code section 11351 (Register 90, No. 72).

§ 10131.2. Notice to Retire Rehabilitation Case File.


HISTORY
1. Change without regulatory effect enacting and amending former section 60123 (in effect 6/26/17) to sections 10131.1 through 10131.25 (enacted 1/28/19) and former section 10131 (in effect 12/27/18) to section 10131.2 (enacted 5/30/19) (Register 91, No. 20). For prior history, see Register 90, No. 4.
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§ 10132.1

VOCATIONAL REHABILITATION FEES SCHEDULE

All fees for services provided under the Vocational Rehabilitation Act of 1984 shall be charged at rates established by the Division of Workers' Compensation. The fees shall be as set forth in this regulation and shall be subject to periodic adjustment by the Administrator of the Division of Workers' Compensation.

1. Charges for the following services provided under the Vocational Rehabilitation Act of 1984 shall be charged at the rates set forth in this regulation:
   a. Evaluation services
   b. Placement services
   c. Training services
   d. Administrative services

2. Charges for services provided under the Vocational Rehabilitation Act of 1984 shall be based on the following factors:
   a. The complexity of the services provided
   b. The extent of the services provided
   c. The time required to provide the services
   d. The qualifications of the provider

3. Charges for services provided under the Vocational Rehabilitation Act of 1984 shall be paid as follows:
   a. At the time of service
   b. On a monthly basis
   c. On a quarterly basis

4. Charges for services provided under the Vocational Rehabilitation Act of 1984 shall be subject to reimbursement by the party responsible for the cost of the services.

5. Charges for services provided under the Vocational Rehabilitation Act of 1984 shall be paid in accordance with the provisions of the Workers' Compensation Act.

6. Charges for services provided under the Vocational Rehabilitation Act of 1984 shall be reviewed and adjusted periodically by the Administrator of the Division of Workers' Compensation.
### Professional Hourly Rate

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<th>Code</th>
<th>Description</th>
<th>Schedule</th>
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<tr>
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<td>61</td>
<td>Three Day</td>
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<tr>
<td>62</td>
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<td>63</td>
<td>Eight Day</td>
<td>$1000</td>
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<td>30</td>
<td>30 Day QRG Benefit Call</td>
<td>Actual time at professional hourly rate, not to exceed 5 Hours</td>
</tr>
<tr>
<td>31</td>
<td>Job Analysis &amp; Review of Disability at Time of Injury</td>
<td>Actual time at professional hourly rate, not to exceed 5 Hours</td>
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**PHASE ONE: EVALUATION OF VOCATIONAL FEASIBILITY MAXIMUM AGGREGATE PERMISSIBLE FEES NOT TO EXCEED $1200**

**面试面谈**

**Interview**

- 32 Actual time, not to exceed 5 Hours

**包括**

- 初始文件审查
- 与工人及其代表接触
- 职业评价评估

**包括**

- 初始文件审查
- 与工人及其代表接触
- 职业评价评估

**Vocational/Work Evaluation Services**

- 适当的服务模块

**须根据需要安排**

**PHASE TWO: PLAN DEVELOPMENT MAXIMUM AGGREGATE PERMISSIBLE FEES NOT TO EXCEED $2500**

**Vocational Testing & Report**

- 评估时间，不超 5 小时

**Consulting & Research Service**

- 适当的时间

**DWC Form RU-102**

- 评估时间，不超 1 小时

**DWC Form RU-102**

- 评估时间，不超 2 小时

**所有相关文件和报告的完成**

**Page 1270**

**RevISED No. 18-3-18-96**
Division of Workers’ Compensation

Appendix F

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Title 8

Service
Code 8

Item Description

Schedule

45
Plan Monitoring
Actual time, as reported.
Includes all activities necessary to ensure the completion of the plan.
May involve contact with worker, assessing facility or OSH employer.
46
Plan Monitoring Report
Actual time, not to exceed 3 hours.

PHASE TWO: JOB PLACEMENT

MAXIMUM AGGREGATE PERMISSIBLE FEES NOT TO EXCEED $3000

41
Job Seeking Skills
Actual time not to exceed 4 hours at $65/hour.
All activity directed toward providing the worker with skills, resume preparation, and personal presentation necessary to obtain employment.
42
Job Placements
Actual time at $65/hour.
Job placement services, placement follow-up, and placement counseling.

INTERPHASE SERVICES (permitted to all phases, to be charged during the phase in which the activity occurs and included within the maximum aggregate expenditure for each phase)

21
Travel Rate
Not to exceed 53.30/100 per mile.
plus $0.24 per mile.

51
Telephone Calls
Actual time.

52
File Review/Document Review
Actual time at $65.00.
After an initial review, file review is billable activity only for re-opening or re-investigation of a file, or for conference purposes. Review of new medical/legal reports, or work evaluation reports, upon request, is billable activity.

35
Counseling & Research Services
Actual Time at
Professional Hourly Rate

53
Reporting
The fee for completion of the Vocational Rehabilitation Progress Report, Form 81-121,
is $30.00 at Professional Hourly Rate.

For narrative reports in the request of a party other than otherwise specified, three minutes of
an hour per page, up to one and one half hour maximum.

54
Rehabilitation Unit Conference
Informal Conference & Professional Appearance
Actual time at professional hourly rate.
Preparation time up to one hour.

Education & Training
As between schools of equal merit, preference will be given to those schools who have reduced their tuition rates by 10% from published 1989 tuition rates, in accordance with the reduction required by Labor Code section 1999.5(a)(4). Denomination reflecting the tuition reduction shall be identifiable upon request. Vocational schools may not charge a tuition rate for rehabilitation students which is greater than the lowest rate that would be given to the general public.

90
Extraordinary Services/Expenses
For Dates of Injury prior to 1/1/96.

It is recognized that there are occasionally extraordinary circumstances which may require services and fees beyond those listed. Billings above the recommended fee schedule shall require additional documentation prior authorization, for excess billings should be submitted before service delivery.

**TREATING PHYSICIAN'S REPORT OF DISABILITY STATUS**

**INSTRUCTIONS:** Please fill out this form and return it to the employer within 15 days of receipt. The form is for use in determining the employee's ability to return to work or perform modified duties.

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>(Name)</th>
<th>(Address)</th>
<th>(City)</th>
<th>(State)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

**EMPLOYMENT**

**JOB TITLE:**

**DATE:**

**SPECIAL CONSIDERATIONS:**

1. **With or without the following medical condition:**
   - [ ] Yes
   - [ ] No

**PHYSICIAN'S REPORT**

**Physician's Name:**

**Physician's Signature:**

**EMPLOYER'S APPROVAL**

**Date:**

**EMPLOYER'S SIGNATURE:**

**EMPLOYER'S ADDRESS:**

**EMPLOYER'S CITY:**

**EMPLOYER'S STATE:**

**EMPLOYER'S ZIP CODE:**

*Note: This is a sample of the form used for reporting an employee's disability status to the employer. The actual form may vary depending on the state and jurisdiction.*
**Description of Employee's Job Duties**

**Instructions:** This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the employer to determine whether the employee is able to perform work duties. This is an important document and should accurately describe the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Rehabilitation and Assistance Officer at the Division of Workers' Compensation. This phone number can be found in the basic Government section of the phone book.

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>(Last)</th>
<th>(First)</th>
<th>(M.I.)</th>
<th>Claim #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Name:</td>
<td>Job Address:</td>
<td>Job Title:</td>
<td>8 Hrs. Worked Per Day:</td>
<td>8 Hrs. Worked Per Week:</td>
</tr>
</tbody>
</table>

**Description of Job Responsibilities:** (Describe All Job Duties)

1. Check the frequency of activity required of the employee to perform the job.

<table>
<thead>
<tr>
<th>Activity</th>
<th>(Hours Per Day)</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 Hours</td>
<td>1-5 Hours</td>
<td>6-10 Hours</td>
<td>11+ Hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*DWC Form RU-91 (2/95)*
### 2. Please indicate if daily Lifting and Carrying requirements of the job. Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

<table>
<thead>
<tr>
<th>Lifting</th>
<th>Carrying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Distance</td>
</tr>
<tr>
<td>0-10 lbs</td>
<td></td>
</tr>
<tr>
<td>11-20 lbs</td>
<td></td>
</tr>
<tr>
<td>21-30 lbs</td>
<td></td>
</tr>
<tr>
<td>31-50 lbs</td>
<td></td>
</tr>
<tr>
<td>&gt;50 lbs</td>
<td></td>
</tr>
</tbody>
</table>

Describe the heaviest item required to carry and the distance to be carried:

### 3. Please indicate if your job requires:

- a. Driven: cases, boxes, barrels, and other equipment?
- b. Working around equipment and machinery?
- c. Walking on uneven ground?
- d. Exposure to excessive noise?
- e. Exposure to extreme temperature, humidity or weather?
- f. Exposure to dust, gas, fumes, or chemicals?
- g. Working at heights?
- h. Operation of fast controls or repetitive foot movement?
- i. Use of special vision or auditory protective equipment?
- j. Working with bio-hazards such as blood borne pathogens, sewage, hospital waste, etc.

Employee Comments:

Employee Comments:

Employee Contact Name: 

Employee Contact Title: 

Employee Representative Signature: 

Date: 

Employee Signature: 

Date: 

Qualifying Rep. Representative Signature: 

Date: 

DWC Form RU-91 (2/95)
NOTICE OF OFFER OF MODIFIED OR ALTERNATE WORK

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Your employer (name of firm): ___________________________ is offering you the position of a
(name of job): ___________________________

Attached is a list of the duties required of the position.

Signature of the Representative: ________________________

Date of offer: ___________________________, Date job starts: ___________________________

Claims Administrator: ___________________________, Claim Number: _______________________

NOTICE TO EMPLOYEE

You have 30 calendar days to accept or reject this offer of modified or alternate work. If you reject this job offer, you will not be entitled to rehabilitation services unless:

A. You cannot perform the essential functions of the job; or

B. The job is not a regular position lasting at least 12 months; or

C. Wages offered are less than 85% of the wages paid at the time of injury; or

D. The job is beyond a reasonable commuting distance.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Name of employee: ___________________________, Date offer received by employee: ___________________________

Accept this offer of Modified or Alternate work.

Reject this offer of Modified or Alternate work.

Signature: ___________________________, Date: ___________________________

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Rehabilitation Unit with a Case Information Document (DWC Form RU-101) within 30 days of acceptance or rejection.

If a dispute occurs regarding the above offer or agreement, either party may request the Rehabilitation Unit to resolve the dispute by filing a Request for Dispute Resolution (DWC Form RU-103) at the nearest office of the State of California, Department of Workers' Compensation, Rehabilitation Unit.

MANDATORY FORMAT:
STATE OF CALIFORNIA
DWC-251-94 (9/94)
# CASE INITIATION DOCUMENT

**TYPE OF ACTION (SELECT ONE):**
- Original Petition
- Amendment
- Motion
- Petition for Leave to File
- Adjourned Case

**INSTRUCTIONS:** This form must be completed and submitted to the Rehabilitation Unit within 30 days of the date of the notice of proposed change. The form must be submitted to the Rehabilitation Unit office. The case is subject to the jurisdiction of the Rehabilitation Unit office. Any changes to the Rehabilitation Unit office must be made in accordance with the Rehabilitation Unit office's policies and procedures.

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYEE NAME</strong></td>
<td>John Doe</td>
</tr>
<tr>
<td><strong>EMPLOYEE ADDRESS</strong></td>
<td>123 Main St, Any City, CA 90210</td>
</tr>
<tr>
<td><strong>EMPLOYEE TELEPHONE NUMBER</strong></td>
<td>123-456-7890</td>
</tr>
</tbody>
</table>

**QUALIFIED PERSONS REPRESENTATIVE, IF ANY**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALIFIED PERSONS REPRESENTATIVE NAME</strong></td>
<td>Jane Smith</td>
</tr>
<tr>
<td><strong>QUALIFIED PERSONS REPRESENTATIVE TITLE</strong></td>
<td>Attorney</td>
</tr>
<tr>
<td><strong>QUALIFIED PERSONS REPRESENTATIVE ADDRESS</strong></td>
<td>456 Park Ave, Any City, CA 90210</td>
</tr>
</tbody>
</table>

**EMPLOYER REPRESENTATIVE, IF ANY**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPLOYER REPRESENTATIVE NAME</strong></td>
<td>John Doe</td>
</tr>
<tr>
<td><strong>EMPLOYER REPRESENTATIVE TITLE</strong></td>
<td>President</td>
</tr>
<tr>
<td><strong>EMPLOYER REPRESENTATIVE ADDRESS</strong></td>
<td>123 Main St, Any City, CA 90210</td>
</tr>
</tbody>
</table>

**SUBMITTED BY:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUBMITTED BY NAME</strong></td>
<td>John Doe</td>
</tr>
<tr>
<td><strong>SUBMITTED BY TITLE</strong></td>
<td>Attorney</td>
</tr>
<tr>
<td><strong>SUBMITTED BY ADDRESS</strong></td>
<td>123 Main St, Any City, CA 90210</td>
</tr>
</tbody>
</table>

**REHABILITATION UNIT IS DUE:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REHABILITATION UNIT IS DUE</strong></td>
<td>[Date]</td>
</tr>
</tbody>
</table>

*Must be printed on Goldramp paper or approved supplement prepared with Goldramp borders.*
VOCATIONAL REHABILITATION PLAN

INSTRUCTIONS: This form shall be used for submitting a vocational rehabilitation plan to the Rehabilitation Unit for injuries in accordance with L.C. §4638. For injuries prior to 1/1/84, the claims administrator shall submit the signed form with medical and vocational reports to the Rehabilitation Unit for approval.
For injuries occurring on or after 1/1/84 where the employee is not represented by an attorney, the claims administrator shall submit this signed form and all medical and vocational reports, not previously submitted, to the appropriate Rehabilitation Unit within 10 days of completion. If a Rehabilitation Unit case number has not been assigned, attach a completed Case Initiation Document (DWC RU-101).

SECTION A

<table>
<thead>
<tr>
<th>EMPLOYER NAME</th>
<th>(L)</th>
<th>(M)</th>
<th>(S)</th>
<th>RU CASE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>(STREET)</td>
<td>(CITY)</td>
<td>(STATE)</td>
<td>(ZIP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLAIMS ADMINISTRATOR</th>
<th>(NAME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>(STREET)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION B

<table>
<thead>
<tr>
<th>OCCUPATION AT INJURY</th>
<th>EARNINGS AT INJURY</th>
<th>DATE OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DETAILED TYPE OF INJURY AND MEDICAL LIMITATIONS: (Also identify medical report relied upon)

SUMMARY OF EMPLOYER'S EDUCATIONAL AND VOCATIONAL BACKGROUND AND EXPLANATION OF HOW TRANSFERABLE SKILLS HAVE BEEN USED IN SELECTION OF THE PLAN OBJECTIVE:

INITIALS

REHABILITATION UNIT USE ONLY

Mandatory Format

DWC Form RU-102 (pg. 1 of 4)
### SECTION C

<table>
<thead>
<tr>
<th>Vocational Objective</th>
<th>Achievable Weekly Earning Upon Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Type of Plan</strong></td>
</tr>
<tr>
<td></td>
<td><strong>With the Same Employer</strong></td>
</tr>
<tr>
<td></td>
<td>1. Modified Job</td>
</tr>
<tr>
<td></td>
<td>2. Alternate Work</td>
</tr>
<tr>
<td></td>
<td><strong>With New Employer</strong></td>
</tr>
<tr>
<td></td>
<td>3. Direct Placement</td>
</tr>
<tr>
<td></td>
<td>4. On-the-Job Training</td>
</tr>
<tr>
<td></td>
<td>5. Educational Training</td>
</tr>
<tr>
<td></td>
<td>6. Self-Employment</td>
</tr>
</tbody>
</table>

**Describe Nature and Extent of Rehabilitation Plan:**

**Date Vocational Feasibility Determined:**

**Plan Commencement Date:**

**Expected Completion Date (including placement assistance):**

**# Weeks of Training:**

**# Weeks of Placement Assistance:**

<table>
<thead>
<tr>
<th>Initials</th>
</tr>
</thead>
</table>

Mandatory Format

OwC Form RU-102 (pg. 2 of 4)
**BUDGET FOR VOCATIONAL REHABILITATION PLAN EXPENDITURES**

Identify incurred and estimated costs for this rehabilitation plan. For injuries on or after 1/1/94, the maximum expenditure for vocational rehabilitation expenses shall not exceed $16,000.

### RESOURCES TO EMPLOYEE

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRMA/VRTD paid to date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRMA/VRTD to be paid every 14 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount withheld for Attorney Fees, if any</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total weekly benefit payments to employee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation expenses to be paid as follows</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLAN EXPENDITURES

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training/tuition fees, if any (specify recipient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other costs (specify type, recipient, and method of payment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FEES FOR EVALUATION, PLAN DEVELOPMENT & PLACEMENT

(List Evaluation and Plan Development fees to date and estimated fees for Plan Monitoring and Placement)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Plan Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Plan Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Placement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATE OF PLAN EXPENDITURES**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
</table>

### ADDITIONAL RESOURCES TO EMPLOYEE

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Disability Supplement paid to date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Disability Supplement to be paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other resources to be provided to employee (identify source and amount):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION D

1. List results of vocational testing, if any, and how they support the vocational objective.

2. Describe why this employee will be employable in the vocational objective of this plan. Include assessment of labor market.

Mandatory Form

DWC Form RU-102 (pg. 3 of 4)
**SECTION E**

**RESPONSIBILITIES OF THE CLAIM ADMINISTRATOR:**

The claim administrator shall timely provide all vocational services and benefits authorized by the agreement between the rehabilitation provider and as required by the Labor Code. The administrator shall notify the claimant that the services provided are in compliance with the Rehabilitation Act of 1973.

**RESPONSIBILITIES OF THE EMPLOYEE:**

The employee shall be available and reasonably cooperate in the provision of vocational rehabilitation services. The employee shall serve on time and participate in all scheduled activities. Failure to do so shall result in termination of services.

The employee shall inform the rehabilitation provider of any changes in employment status or any other change that may affect the claim.

**SECTION F**

**VERIFICATION OF THE PLAN:**

1. This plan was developed by the employer and approved by the state rehabilitation agency. The plan will provide the employee with the opportunity to return to gainful employment.

2. The employee has been advised that the services provided under this plan will be for the purpose of rehabilitation and do not constitute a contract for employment.

**SIGNATURE:**

Employee:

Date:

**SECTION G**

**PLAN AGREEMENT**

Signature of the claim administrator and employee on this plan shall be deemed to be an agreement that the services and services rendered are in accordance with the provisions of this plan.

Failure to provide the services required by the plan may result in the employee being entitled to additional services.

Failure of the employee to comply with the provisions and schedules developed for this plan may result in termination of the employee's liability for rehabilitation services.

I have read and understand all of the provisions of this plan and agree to all of the plan's provisions.

**NAME OF EMPLOYEE:**

Signature:

Date:

**NAME OF EMPLOYEE REPRESENTATIVE:**

Signature:

Date:

**ADDRESS OF EMPLOYEE REPRESENTATIVE:**

**PERSON AUTHORIZED TO SIGN ON BEHALF OF THE EMPLOYER:**

Name:

Signature:

**PERSON SIGNING THIS SECTION SHALL ALSO INITIAL THE OTHER THREE PAGES IN INITIAL BOX.**
REQUEST FOR DISPUTE RESOLUTION

DO NOT USE THIS FORM WHEN LIABILITY FOR THE INJURY IS DISPUTED.

INSTRUCTIONS: This is to be used when the parties are unable to resolve disputed rehabilitation issues and a determination by the Rehabilitation Unit is required. The completed form must be accompanied by all medical and vocational reports, including an indemnity claim, and any other pertinent information not previously submitted to the Rehabilitation Unit. The parties are expected to meet prior to filing this request in an effort to initially resolve disputed issues. This request must be sent to the appropriate Rehabilitation Unit office. If a case number has not been assigned, submit a completed Case Information Document (DWC Form RL-101). Please note: An expedited conference is a procedure designed to resolve single issues as identified herein. Other issues will be resolved either by a separate conference or a determination on the submitted record.

<table>
<thead>
<tr>
<th>EMPLOYER NAME</th>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Rehabilitation Unit is requested to resolve the following dispute(s) as an expedited basis because the parties disagree over (Check the single issue which applies)

- the description of the employee's job duties at the time of injury (for injuries after 1/1/04)
- the selection of the Qualified Rehabilitation Professional
- the employee object to the amended Notice of Intent to Withhold Maintenance Allowance
- the identification of a vocational goal (for injuries after 1/1/04)

Other disputed issues:

- the employee objects to a Notice of Termination of Vocational Rehabilitation Services
- the employee's medical eligibility for vocational rehabilitation services.

Medical reports relied upon by respondent:

Other (specify):

SUMMARY OF PARTIES' INFORMAL EFFORTS TO RESOLVE THIS DISPUTE:

An informal conference was held on __________. A summary of the conference including a list of records, issues addressed, agreements reached, and unresolved issues is attached. If an informal conference was not held, state explanation.

Copies of this report with copies of relevant vocational reports have been served on:

<table>
<thead>
<tr>
<th>Has the employer/career counseling district's claim?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the injury been covered by WCAB?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has more than 90 days TTD been paid?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

MANDATORY FORMAT
STATE OF CALIFORNIA
DWC FORM RL-102 2/05

Page 1251

Page 112 of Doc. 7-2-2016
NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES

TO: ____________________________________________________________

CLAIM #: _______________________________________________________

Rehab Unit #: ___________________________________________________

Social Security #: ________________________________________________

We have determined we no longer are required to provide Vocational Rehabilitation Services to you because: (Insert reason for Termination of Vocational Rehabilitation Services)

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future.

If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reasons for them to the Rehabilitation Unit within 20 days of receipt of this notice. The form to use to make your objection is enclosed. Be sure to send a copy to me. The Rehabilitation Unit will then determine if you are to be given further services. Please send a copy of this notice with your objection to the Rehabilitation Unit located at: (Insert Rehabilitation Unit address)

If you have any questions about this notice, you may contact me at ____________________________

SUMMARY OF SERVICES PROVIDED

<table>
<thead>
<tr>
<th>Number of weeks of VRMC:</th>
<th>Number of weeks of VRPR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount VRMC:</td>
<td>Total Amount VRPR:</td>
</tr>
<tr>
<td>Paid</td>
<td>Paid</td>
</tr>
<tr>
<td>Total Amount VR Suppl:</td>
<td>Total Amount VR Suppl:</td>
</tr>
<tr>
<td>________________________</td>
<td>________________________</td>
</tr>
<tr>
<td>Amount Paid QRS for:</td>
<td>Amount Paid QRS for:</td>
</tr>
<tr>
<td>Evaluation:</td>
<td>Evaluation:</td>
</tr>
<tr>
<td>Plan Development:</td>
<td>Plan Development:</td>
</tr>
<tr>
<td>Monitoring:</td>
<td>Monitoring:</td>
</tr>
<tr>
<td>Total costs of QRS service:</td>
<td>Total costs of QRS service:</td>
</tr>
<tr>
<td>QRS Name:</td>
<td>QRS Name:</td>
</tr>
<tr>
<td>Total other costs of rehabilitation services:</td>
<td>Total other costs of rehabilitation services:</td>
</tr>
<tr>
<td>Amount needed for employee's reintegration, if any:</td>
<td>Amount needed for employee's reintegration, if any:</td>
</tr>
</tbody>
</table>

(Submit by: (Signed))

(Names)

(Title)

(Official Title)

(Phone Number)

(Official Title)

(City, State, ZIP)

PAGE 200

BARCLAYS CALIFORNIA CODE OF REGULATIONS

APPENDIX F

Page 22

This 9

Section 1013

NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES

TO: ____________________________________________________________

CLAIM #: _______________________________________________________

Rehab Unit #: ___________________________________________________

Social Security #: ________________________________________________

We have determined we no longer are required to provide Vocational Rehabilitation Services to you because: (Insert reason for Termination of Vocational Rehabilitation Services)

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future.

If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reasons for them to the Rehabilitation Unit within 20 days of receipt of this notice. The form to use to make your objection is enclosed. Be sure to send a copy to me. The Rehabilitation Unit will then determine if you are to be given further services. Please send a copy of this notice with your objection to the Rehabilitation Unit located at: (Insert Rehabilitation Unit address)

If you have any questions about this notice, you may contact me at ____________________________

SUMMARY OF SERVICES PROVIDED

<table>
<thead>
<tr>
<th>Number of weeks of VRMC:</th>
<th>Number of weeks of VRPR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount VRMC:</td>
<td>Total Amount VRPR:</td>
</tr>
<tr>
<td>Paid</td>
<td>Paid</td>
</tr>
<tr>
<td>Total Amount VR Suppl:</td>
<td>Total Amount VR Suppl:</td>
</tr>
<tr>
<td>________________________</td>
<td>________________________</td>
</tr>
<tr>
<td>Amount Paid QRS for:</td>
<td>Amount Paid QRS for:</td>
</tr>
<tr>
<td>Evaluation:</td>
<td>Evaluation:</td>
</tr>
<tr>
<td>Plan Development:</td>
<td>Plan Development:</td>
</tr>
<tr>
<td>Monitoring:</td>
<td>Monitoring:</td>
</tr>
<tr>
<td>Total costs of QRS service:</td>
<td>Total costs of QRS service:</td>
</tr>
<tr>
<td>QRS Name:</td>
<td>QRS Name:</td>
</tr>
<tr>
<td>Total other costs of rehabilitation services:</td>
<td>Total other costs of rehabilitation services:</td>
</tr>
<tr>
<td>Amount needed for employee's reintegration, if any:</td>
<td>Amount needed for employee's reintegration, if any:</td>
</tr>
</tbody>
</table>

(Submit by: (Signed))

(Names)

(Title)

(Official Title)

(Phone Number)

(Official Title)

(City, State, ZIP)
INSTRUCTIONS:

This notice is to be used when the claims administrator terminates vocational rehabilitation services. The claims administrator must provide the reason for termination and it must be the exact wording of one of the seven reasons for termination listed below.

The claims administrator must complete the Summary of Services Provided section and provide the employee with a Case Initiation Document (DWC Form RU 101) and Request for Dispute Resolution (DWC Form RU 103).

REASONS FOR TERMINATION OF VOCATIONAL REHABILITATION SERVICE

1. You have signed a "Statement of Declination" form indicating you do not wish rehabilitation services.

2. You have completed a vocational rehabilitation plan.

3. You have unreasonably failed to complete a vocational rehabilitation plan.

4. You failed to request vocational rehabilitation services within 90 days of our offer to provide services.

5. Your employer has offered to provide you modified work lasting at least 12 months.

6. Your employer has offered to provide you alternative work which, a) you are capable of performing, b) is a regular position lasting at least 12 months, c) offers wages and compensation within 15% of your previous wages, and d) is located within a reasonable commute distance.

7. You have accepted a job provided by your employer.
EMPLOYEE STATEMENT OF DECLINATION OF VOCATIONAL REHABILITATION SERVICES

INSTRUCTIONS: This form is to be used by eligible applicants or employees when the employee declines rehabilitation following certification of medical eligibility. It must be signed by the employees and their representatives, if any, and submitted by the claims administrator to the Rehabilitation Unit along with a properly completed Notice of Termination of Vocational Rehabilitation Services (DWC Form RU-105). If a Termination Order is issued, it must be endorsed by the Claims Manager (DWC Form RU-102).

Employee Name | Last Name | First Name | Middle Initial | RU Case #
--- | --- | --- | --- | ---

NOTICE TO EMPLOYEE

The purpose of this form is to formally record your desire to end your right to rehabilitation benefits. If you decline rehabilitation services, your right to rehabilitation services will end. This means your employer may no longer provide you with rehabilitation services to you at a later date, unless otherwise determined pursuant to the Rules and Regulations of the Workers' Compensation Appeals Board in accordance with Labor Code Section 5410.

DESCRIPTION OF VOCATIONAL REHABILITATION SERVICES

If you have a work-related injury or illness which prevents you from doing your former job and your employer cannot take you back, you are entitled to receive rehabilitation services. This amount of services you receive will depend on your needs and abilities.

Vocational rehabilitation services help you to get another job, through job placement or training - whichever is best for you. The rehabilitation costs, including course work and maintenance allowance, are paid by your employer subject to the statutory limits. You have a right to an evaluation to determine the vocational training necessary to you prior to making this decision. Your right to rehabilitation is separate from your other Workers’ Compensation Benefits and cannot be terminated by a work request to you. If you are not ready to participate now in rehabilitation, but might be later, it may be possible to delay your participation in rehabilitation for a period of time.

If you want more information, you may contact an information and assistance officer with the Division of Workers’ Compensation, at no charge, or you may retain an attorney.

STATEMENT OF DECLINATION

This form must be signed by the injured employee.

The injured employee states:

I have read the statement of Declaration for Vocational Rehabilitation Services.
I have received the pamphlet "Help in Returning to Work 94."
I understand rehabilitation.
I understand by signing this form I am giving up a service to which I am entitled.

EMPLOYER’S SIGNATURE ______________________ Date ______________________

Representative’s signature, if any:

The representative states:

I have reviewed this form with my client.
I have explained the effects of declining vocational rehabilitation benefits.

EMPLOYER’S REPRESENTATIVE’S SIGNATURE ______________________ Date: ______________________

REHABILITATION UNIT USE ONLY

DWC FORM RU-107 (AUG 94)
Appendix F

Help In Returning To Work – ‘94

Vocational Rehabilitation Benefits for Workers Injured after January 1, 1994

What is vocational rehabilitation?

Vocational rehabilitation is a worker’s compensation benefit that helps injured workers return to work.

You qualify for vocational rehabilitation if you can no longer do your old job, and your employer does not offer you another.

In the past, a plan to return you to work usually was developed by a vocational counselor — with assistance from you and your claims administrator, the person who is handling your claim for your employer or your employer’s insurance company.

California law limits the amount of money for rehabilitation services.

How do I find out if I’m eligible for vocational rehabilitation services?

When you are off work for 90 days, your claims administrator will give the doctor who is treating you a job description which lists the exact duties you perform at work.

Your claims administrator will ask for your help in preparing this job description. This is to make sure that your doctor has an accurate picture of your job duties.

Your participation is very important, because if you do not assist, the claims administrator may send your doctor the employer’s description of your job.

If you need help filling out the job description form, you may contact the Division of Workers’ Compensation (DWC) information and assistance office. (See list for the phone number of the office nearest you.)

Once your doctor reports whether you can return to your job, you will receive a letter from the claims administrator and a copy of the doctor’s final report.

If you are unable to return to your old job, your employer will decide whether you can return to any other work with your disability.

You should receive a notice in about a month.

You will not qualify for rehabilitation services if you reject or fail to accept within 30 days your employer’s offer of suitable work.

What if the job my employer offered does not work out?

You may still be entitled to rehabilitation services if the job doesn’t last for 12 months or your disability prevents you from performing the task.

If you have concerns, talk to your employer, claims administrator, or information and assistance officer.

What if my employer does not offer me a job?

You will receive an offer of vocational rehabilitation services. You have 90 days to accept. You may ask for an evaluation to help you decide.

If you want services but can’t start immediately, you should let your claims administrator know and ask about the possibility of delaying services.

If you do not wish rehabilitation at all, you may decline these services by signing a form. This ends your employer’s obligation to provide rehabilitation services at a later date.

Can I receive cash instead of rehabilitation services?

No. California law does not permit vocational rehabilitation benefits to be traded for cash.

If I accept vocational rehabilitation, what should I expect?

You and your claims administrator can choose an agency upon whom to develop a rehabilitation plan for you. This can include job modification, job placement assistance, short-term training, and self-employment possibilities — whatever is the best way to return you to work.

You also have the right to request a change of counselor.

What income do I receive if I accept vocational rehabilitation?

If you are receiving temporary disability payments when you start vocational rehabilitation, you may continue receiving them until your doctor reports your condition is “permanent and stationary.” When this occurs, you will then receive a maintenance allowance of up to $240 per week.

There is a 22-week limit to the maintenance allowance, so it is better for you to start your rehabilitation as soon as possible. You may also receive advance payments of permanent disability benefits to supplement the maintenance allowance.

What are the limits of vocational rehabilitation?

The California Legislature has placed very strict limits on rehabilitation plans:

- The plan must be completed within 18 months.
- Vocational rehabilitation maintenance allowance payments are limited to a total of $25,000.
- Once you agree to a plan, changes are limited.
- Total costs, including maintenance allowance, counseling fees, services and expenses, are generally limited to $16,000.
What if I'm already enrolled in a college or university?
If you are already enrolled and have made substantial progress toward a degree or certificate in a community college, state university, or the University of California, you may be able to waive the services of a rehabilitation counselor. Funds normally paid for counseling may then be used to help pay for the college or university program in which you are enrolled. Contact the DWC Rehabilitation Unit for details.

What other services or benefits could I receive as part of the vocational rehabilitation benefit?

- Transportation allowance at a rate specified by the State of California.
- Specific costs required for your rehabilitation plan, such as the cost of renting, supplies, tools and equipment, tuition and student fees.
- Reasonable additional living expenses, such as temporary relocation costs during evaluation or training. This consists of the costs of your food and lodging when you are required to be away from home.
- Reasonable relocation expenses if permanent relocation is required.

Remember, total costs cannot be more than $16,000 except in very limited circumstances.

What are my responsibilities?
You are expected to:
- Take an active role in your rehabilitation.
- Complete assignments.
- Be on time for all appointments, classes, interviews, and scheduled meetings.
- Notify your rehabilitation counselor immediately if you are unable to keep appointments.
- Maintain an accurate, complete travel expense log.
- Stay in contact with and immediately notify your counselor of any problems.
- Keep your counselor and claims administrator advised of any change of your address or phone number.
- Be available for rehabilitation services Monday through Friday, during regular business hours.

You should be aware that if you do not participate fully, your maintenance allowance may be stopped.

What are the claims administrator responsibilities?
The claims administrator is to:
- assist you in returning to work with your employer.
- pay you benefits that are due.
- pay for rehabilitation services and expenses that are agreed upon.
- notify you of changes in benefits.
- submit required paperwork to DWC.
- respond to your questions.

If your claims administrator causes a delay in the provision of services, you may be entitled to additional benefits which could extend beyond the $16,000 limitation. You may file a Request for Dispute Resolution (DWC Form RU-103) if you wish a written determination as to whether there was a delay.

How do I request assistance from the DWC Rehabilitation Unit?
We hope that you can resolve problems informally with your claims administrator. However, the DWC Rehabilitation Unit is the agency responsible for resolving disputes in vocational rehabilitation.

You can contact the Rehabilitation Unit by phone, or you may request assistance by completing a Request for Dispute Resolution (DWC Form RU-103). (See the front of the book for the phone number of the office nearest you.)

There is also a toll-free information number you may call for a recorded message - 1-800-736-7401. You may also request any forms or printed information that you may need by calling the toll-free number.

Should I have an attorney represent me? How much will it cost?
Both the DWC rehabilitation counselor and the information and assistance officer are available to help at no cost to you.

If you decide you want the services of an attorney, you should be aware that your weekly vocational rehabilitation maintenance allowance payment (VRMA) may be reduced to pay the attorney. Generally 12% of your weekly VRMA is set aside for payment of attorney fees. For example, if you are entitled to a maximum rate of $240 per week, a 12% reduction means that you would receive $216.48 per week. For this reason, you should discuss attorney perform with the attorney.

What other rights do I have?
The Federal Americans with Disabilities Act (ADA) prohibits discrimination against qualified individuals. Qualified individuals include persons who have a physical or mental impairment that substantially limits one or more major life activities, and who can perform essential job functions. The employer is required to provide a reasonable accommodation if it would not impose an "undue hardship" on the employer.

For information on the Americans with Disabilities Act, call the Equal Employment Opportunity Commission at 1-800-USA-EOC.

The state Department of Fair Employment and Housing administers California laws which prohibit harassment or discrimination in employment, housing and public accommodations. If you feel an employer has discriminated against you, and you want information, the phone number is 1-800-884-1884.

Here are some helpful phone numbers:
This publication is intended to answer the most frequently asked questions.

It may not necessarily provide a solution for your particular problem, because the specific facts of your situation may call for a different approach. The information contained here is general in nature, and not intended as a substitute for legal advice.

If you have more questions after reading this publication, contact one of the DWC information and assistance officers or rehabilitation offices listed below:
APPENDIX F
Division of Workers’ Compensation

DISTRICT OFFICES OF THE DIVISION OF WORKERS’ COMPENSATION

AGOURA HILLS
Information and Assistance
(818) 901-5374 or
(805) 654-4900
Rehabilitation Consultant
(818) 901-5443

ANAHEIM
Information and Assistance
(714) 738-4038
Rehabilitation Consultant
(714) 538-4581

BAKERSFIELD
Information and Assistance
(661) 395-2514
Rehabilitation Consultant
(209) 445-5066

EUREKA
Information and Assistance
(707) 441-5723
Rehabilitation Consultant
(916) 225-2659

FRESNO
Information and Assistance
(209) 445-5066
Rehabilitation Consultant
(209) 445-5066

GROVER BEACH
Information and Assistance
(805) 481-5265
Rehabilitation Consultant
(805) 481-5265

LONG BEACH
Information and Assistance
(310) 590-5240
Rehabilitation Consultant
(310) 590-5033

LOS ANGELES
Information and Assistance
(213) 897-1488
Rehabilitation Consultant
(213) 897-1475

NORWALK
Information and Assistance
(310) 465-7107
Rehabilitation Consultant
(310) 465-2363

OAKLAND
Information and Assistance
(510) 286-1388
Rehabilitation Consultant
(415) 557-4960

PASADENA
Information and Assistance
(626) 578-4664
Rehabilitation Consultant
(213) 897-1475

POMONA
Information and Assistance
(909) 623-8568
Rehabilitation Consultant
(909) 623-8568

REDDING
Information and Assistance
(916) 225-2047
Rehabilitation Consultant
(916) 225-2599

SACRAMENTO
Information and Assistance
(916) 263-2741
Rehabilitation Consultant
(916) 263-2900

SALINAS
Information and Assistance
(408) 443-3068
Rehabilitation Consultant
(408) 277-1102

SAN BERNARDINO
Information and Assistance
(909) 583-4022
Rehabilitation Consultant
(909) 583-4073

SAN DIEGO
Information and Assistance
(619) 525-4289
Rehabilitation Consultant
(619) 525-4203

SAN FRANCISCO
Information and Assistance
(415) 557-0554
Rehabilitation Consultant
(415) 557-3915

SAN JOSE
Information and Assistance
(408) 277-1297
Rehabilitation Consultant
(408) 277-1102
§ 10133.3

BARCLAYS CALIFORNIA CODE OF REGULATIONS

Page 28

§ 10133.3

BARCLAYS CALIFORNIA CODE OF REGULATIONS

Page 28

State of California

Department of Industrial Relations
Division of Workers' Compensation
Rehabilitation Unit

ANONYMOUS FILING

Workers' Compensation Claim

MAY BE FINED UP TO $10,000 AND SENT TO PRISON FOR UP TO FIVE YEARS.

[Insurance Code Section 1871.4]
### INITIAL EVALUATION SUMMARY

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<td>b)</td>
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<tr>
<td>a)</td>
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</table>

DWC Form R-120 (Page 1 of 4) (02/95)
### INITIAL EVALUATION DATA SHEET

**PERSONAL INFORMATION:** Name:

- Male: [ ] Female: [ ]
- Social Security No.: [ ]
- DOB: [ ]
- Phone No.: [ ]
- CA Driver's License No.: [ ]
- Exp. Date: [ ]

**License Restrictions (Explain):**

**Distance willing to travel to work (one way):**

**Areas willing to drive:**

**Reliable vehicle available for transportation (full-time):**

- Yes [ ]
- No [ ]

If no, what method of transportation will be used:

**Willing to relocate?**

- Yes [ ]
- No [ ]

**Work Shifts:**

- All Days: [ ]
- All Shifts: [ ]
- M-F Only: [ ]
- 8-5 Only: [ ]

**Describe issues which may interfere with worker's participation in services:**

### SOCIO-FAMILY FINANCIAL HISTORY

**Marital status:**

- Married [ ]
- Single [ ]
- Divorced [ ]
- Widowed [ ]
- Separated [ ]

**Number of Dependents Living at Home:**

- Age: [ ]
- Child Support Payments: [ ]
  - Yes [ ]
  - No [ ]
- Amount: [ ]

**Child care required:**

- Yes [ ]
- No [ ]

- Estimated amount per week: [ ]

**Able to financially support self throughout duration of services:**

- Yes [ ]
- No [ ]

(Explain):

**Receiving UI/RMA?**

- Yes [ ]
- No [ ]

Amount per week: [ ]

**Receiving PD Supplement?**

- Yes [ ]
- No [ ]

Amount per week: [ ]

**Other sources of income (explain):**

### EDUCATIONAL BACKGROUND

**High School Graduate:**

- Yes [ ]
- No [ ]

**Name & Location of High School:**

**If not high school graduate, GED?**

- Yes [ ]
- No [ ]

**Year:**

**Post-HS Studies:**

- Certificate: [ ]
- AA/AS: [ ]
- BA/BS: [ ]

**Area of Study:**

**Year:**

**English Language:**

- Speak [ ]
  - Yes [ ]
  - No [ ]

- Read [ ]
  - Yes [ ]
  - No [ ]

- Write [ ]
  - Yes [ ]
  - No [ ]

**Other Language:**

- Speak [ ]
  - Yes [ ]
  - No [ ]

- Read [ ]
  - Yes [ ]
  - No [ ]

- Write [ ]
  - Yes [ ]
  - No [ ]

**Worker's List of Perceived Work Skills:**

---

DWC Form RU-120 (Page 2 of 4) (02-99)
### MILITARY SERVICE
- Dates of Service: 
- Branch: 
- Special Skills: 

### VOCATIONAL HISTORY

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### MEDICAL FILE REVIEW
- Treating Physician: 
- Phone: 
- Address: 
- Injury/Diagnosis: 
- Permanent & Stationary: Yes  No  
- Medical Restrictions/Limitations (specify medical report and date mailed upon): 
- Current Medications (specify medical report and date mailed upon): 
- Currently in Physical Therapy: Yes  No  
- Non-Industrially Related Medical Conditions (explain): 

### PRESENT PHYSICAL TOLERANCES (Subjective)

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<tr>
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<td>minutes</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
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</table>

Vision Restrictions: Yes  No  
Ready to Return to Work: Yes  No  

Supplemental Medical/Physical Information: 

---

DWC Form RU-120 (Page 3 of 4) (02/95)
Appendix F
Page 32

BARCLAYS CALIFORNIA CODE OF REGULATIONS
Title 8

VOCATIONAL CONSIDERATIONS

Preliminary Assessment of Transferable Skills:

Client's Expressed Interest/Expectations of Vocational Rehabilitation:

Observations (Comments on Appearance, Rapport, Cooperation, Attitude):

VOCATIONAL FEASIBILITY FACTORS

Can the employee reasonably benefit from the provision of vocational rehabilitation services?

INVESTIGATION OF MODIFIED/ALTERNATE EMPLOYMENT

Available

Not Available

Unknown/Not Requested

Contact:

Title:

Date of Conduct:

EXPLANATION OF VOCATIONAL REHABILITATION PROCESS

(Check Box for all issues covered with worker)

EE Role

CBA Limit on VR

Termination Process

QER Role

VRMA

Reinstatement Process

Carrier/ER Role

Dispute Resolution Process

Interim Process

Rehab Unit Role

Effect of Delays

Allowable Costs

Help RTW Brochure

Plan Definition

Nature, Rates, Allocated Costs

Plan Hierarchy

Plan Parameters

Other (Explain)

DWC Form RU-120 (Page 4 of 4) (02/98)
VOCATIONAL REHABILITATION PROGRESS REPORT #

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Services Provided:

Summary of Activities and Comments:

Recommendations/Plan of Action:

Next Reporting Date:

QRR (Print Name): [Signature: Date:]

Attachments:

Copies Sent To:

Phase I: Phase II: Phase III:

Total: 
§ 10133.4. Rehabilitation of industrially injured inmates.

(a) Inmates of a state penal or correctional institution may be eligible for workers' compensation benefits, including the provision of vocational rehabilitation service, for injuries which occur during their convivial and while engaged in assigned work or employment. As used in this section:

(1) "Assigned work or employment" means work performed in any pay or non-pay position in a work program under the direction and with the approval of a duly authorized inmate administrator or supervisory personnel or Department of Corrections employee. The term does not include skill centers, vocational training or academic education programs (except for physical fitness training and forestry training which are authorized by Labor Code Section 3582) in prerequisite to the suppression, release or activities which are clearly and unambiguously to the duties and responsibilities of line positions to which assigned.

(2) "Inmate of a state penal or correctional institution" means a person committed to the custody of the Department of Corrections and who is in a facility, camp, hospital, or institution of the Department of Corrections for the purpose of confinement, treatment, education, training, or discipline, or who has been temporarily removed by the Department of Corrections from a facility under an order of the court or without custody, for the performance of assigned work. The term does not include a prisoner who has escaped or who has been released on parole.

(3) "Inmate" as used in this section (b) of Section 5062 of the Penal Code, means the Director of Corrections. In addition to the requirements of Sections 10123, 10124 and 10126, the Director of Corrections shall provide notice of the availability of vocational rehabilitation services to inmates disabled for 28 calendar days or more, or a form prescribed by the Director. A copy of such form shall be sent to the Department of Rehabilitation.

(b) Notwithstanding Section 10125, an inmate who otherwise qualifies for vocational rehabilitation services shall not be entitled to vocational rehabilitation unless he allows payments while serving in a state penal or correctional institution.

(c) Vocational rehabilitation services to determine an inmate's eligibility or employed wage and salary income required vocational rehabilitation plan shall be provided by a rehabilitation representative chosen by the Department of Corrections. Such services shall be provided to the inmate for as long as it is feasible and prior to the inmate's release from custody, if possible, with the intent of preparing the inmate for suitable gainful employment upon release. Nothing shall bar the development and implementation of a plan, however, prior to the inmate's release, using modified work or an otherwise suitable work position meeting the definition of assigned work or employment under subsection (a) of this section.


History

1. Repealing former sections 10123 and 10124 and amendment of section 10126 and amendment of section 1307.3, effective January 2, 2016. (Statutes of California, 2000-01, ch. 1433, § 60, effective January 1, 2011.)
Article 8. Attorney Fee Disclosure Statement

§ 10134. Attorney Fee Disclosure Statement Form.

State of California
Department of Industrial Relations
Division of Workers' Compensation

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorney's fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may be liable for any attorney fees you incur because of the dispute.

If at any time you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401.

Employee's Signature ___________________________ Date ____________

Employee's Name ________________________________

Attorney's Signature ___________________________ Date ____________

Attorney's Name ________________________________

Address ________________________________

Phone No. ________________________________

DWC Form 3 (Rev. 3/93)
DECLARACION DE REVELACION DE HONORARIOS

Si Ud. escoge ser representado por un abogado, los honorarios de su abogado serán deducidos de sus beneficios. Los honorarios serán aprobados por el Departamento de Apelaciones de Compensaciones al Trabajador, se le dará consideración a los siguientes: (1) responsabilidad asumida por el abogado; (2) el cuidado ejercido en representarlo a Ud.; (3) tiempo dedicado; y (4) resultados obtenidos.

Los honorarios del abogado normalmente fluctuarán entre un 9% a un 12% de los beneficios otorgados. Si su abogado cambia lo que fue representado a Ud. ante la Unidad de Rehabilitación, también puede ser que se permitan honorarios por esa representación.

Hay ciertas circunstancias en que su empleador (o la compañía de seguros de correspondientes) puede ser responsable o obligado a pagar sus honorarios de abogado. Por ejemplo, si su empleador dirige una evaluación de incapacidad permanente obtenida cuando Ud. no ha sido representado por un abogado, su empleador puede ser responsable o obligado a pagar cualquier honorario de abogado incurrido por la disputa.

Si en cualquier momento Ud. no desea continuar siendo representado por un abogado, Ud. puede retirar la representación con una notificación a su abogado. Si retira Ud. su representación, la cantidad de honorarios será determinada por el juez por cualquier trabajo que el abogado haya efectuado en su caso y esta será deducida de su beneficio otorgado.

Un Oficial de Información y Asistencia podrá responder a sus preguntas en relación a sus beneficios de compensación sin costo alguno para Ud. El podrá resolver sus problemas sin necesidad de litigación. Llame a este número de teléfono gratis: 1-800-756-7401.

Firma del Empleado __________________________ Fecha ____________
Nombre del Empleado _________________________

Firma del Abogado __________________________ Fecha ____________
Nombre del Abogado _________________________
Dirección: _________________________________
Nro. de Teléfono: ___________________________
Article 9. Request for Expedited Hearing
§ 10135. Filing the Request
(a) The Administrative Director shall establish an uniform expedited hearing calendar in all offices of the Division of Workers' Compensation.

(b) An applicant is entitled to an expedited priority hearing and decision upon the filing of an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to:

(1) the necessity for medical treatment;
(2) the amount of temporary disability payments or amounts;
(3) the appropriateness and order of the rehabilitation unit, enforcement thereof, or termination of
(4) whether for benefits among employers;
(c) The request for expedited hearing must be on the form set forth in Section 10137, DWC Form 4, and must be filed with an Application for Adjudication of Claim.

(d) Within two (2) days of receipt of the Request for Expedited Hearing, the Request shall be reviewed for compliance with Subdivision (b).

Notes: Authority: Sections 133 and 5907.1, Labor Code. Reference: Section 4900(e), Labor Code.

History
1. New section added by Stats. 1989, ch. 1107, Sec. 2, effective Jan. 1, 1990. (Register 90, No. 1.)
2. Amendments made in operative file 4-13-89, effective 4-16-89 (Register 90, No. 4, new section is exempt from review by OAL pursuant to Government Code section 11331 (Register 93, No. 10).
§ 10167. Form.

WORKERS COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

CASE NO:

REQUEST FOR EXPEDITED
HEARING AND DECISION
[LABOR CODE SECTION 5802(b)]

Applicant

vs.

Defendant

The applicant hereby, having filed an Application for Adjustment of Claim this date, requests that this case be set for expedited hearing and decision as:

Workers' Compensation Appeals Board

on the following issues:

1. Entitlement to Medical Treatment, per L.C. 4600
2. Establishment of Temporary Disability or Disagreement on Amount of Temporary Disability
3. Appeal from Decision and Order of Rehabilitation Bureau
4. Enrollment in Compensation in Dispute because of Disagreement between Employer and/ or Carrier

Explanation:

APPLICANT STATES UNDER PENALTY OF PERJURY THAT THERE IS A BONA FIDE DISPUTE THAT SHE IS PRESENTLY READY TO PROCEED TO HEARING, THAT HER DISCOVERY IS COMPLETE ON SAID ISSUES, THAT THE TIME REQUIRED FOR HEARING WILL BE

Name (Print or Type)
Signature of applicant
Signature of attorney (if represented)

Date

INSTRUCTION FOR FILING

This request must be filed with an Application for Adjustment of Claim at the appropriate district office of the Appeals Board.

SERVICE

Type or print names and addresses of parties, including attorneys and representatives served with a copy of this request.

DWC Form 4 (10/95)
SOLOITUD PARA EXPEDIR LA AUDICIÓN Y DECISIÓN [CÓDIGO DEL TRABAJO SECCIÓN 5802(b)]

Deseanandro

Contral

Deseando en esta, ha presentado una aplicación para beneficios en esta fecha, requiere que este caso sea dirigido para que se presente la audiencia y decisión

Oficina de Compensación de Trabajadores de la Junta de Apelaciones en los siguientes asuntos:

Tener Dcho a Tratamiento Médico según L.C. 4606
Tener Dcho de Inaplicabilidad Temporal. o estar de descanso con la cantidad de la Inaplicabilidad Temporal
Apelación de la Decisión y Orden de Revisión de Reaplicación
Tener Dcho a recibir compensación en Llego por descanso entre el Empleador y la Compensación de Seguros

Explicación:

EL DEMANDANTE DECLARA SER JUNTO DE MÚLTIPLES QUE AQUELLE UN LITIGIO DE BONA FIDE QUE EL ELLA ESTÁ HOY PREPARADA PARA PROCEDER CON LA AUDICIÓN, QUE SU DESCUBRIMIENTO ES COMPLETO CON LAS CUESTIONES DICHAS QUE LA SOLICITADA HOY SERÁ

Nombre (Escribe en letra de imprenta o maquina)__________________________

Firma del Demandado__________________________

Fecha

INSTRUCCIONES PARA SER PRESENTADO
Esta solicitud debe ser presentada con la Demanda de Audiencia en una Oficina de Compensación de Trabajadores.

SERVICIO
Escribe a máquina o en letra de imprenta los nombres y direcciones de las personas que hayan recibido una copia de esta demanda, incluyendo los abogados y los representantes

DWC Form 4 (02/96)

Page 1386.10(a)
Subchapter 1.6. Permanent Disability Rating Determination

§ 10150. Authority.
The Office of Benefits Determination, Disability Evaluation Unit, under the direction and authority of the Administrative Director, will prepare permanent disability rating determinations. The terms used to identify the various rating determinations have a different and exclusive meaning, and are not to be used interchangeably.


§ 10151. Schedule for Rating Permanent Disabilities.
The Schedule for Rating Permanent Disabilities is revised and issued by the Administrative Director annually. It becomes effective by reference in its entirety on the first day of April each year.


§ 10152. Disability, Whose Consideration Permanent.
A disability is considered permanent if the employee has reached maximum medical improvement or is under treatment or has been totally incapacitated by a reasonably foreseeable period of time. Authority: Section 5507.4, Labor Code. Reference: Sections 132 and 4061, Labor Code.

History:
1. New section filed 6-25-91, operative 6-25-91 (Register 91, No. 26). New section is current from review by OAL pursuant to Government Code section 11801.

§ 10153. Permanent Disability Rating Determinations.

(a) Formal rating determinations
(b) Summary rating determinations
(c) Calculating rating determinations
(d) Informal rating determinations


History:
1. New section filed 6-25-91, operative 6-25-91 (Register 91, No. 26). New section is current from review by OAL pursuant to Government Code section 11801.


§ 10154. Formal Rating Determinations.
A formal rating determination will be prepared by the Disability Evaluation Unit of the Employment Development Department, based on the information and evidence presented by the employee and the employer. A copy of the formal rating determination shall be served on the employee and the employer, and a copy shall be served on the Administrative Director.


History:
1. New section filed 6-25-91, operative 6-25-91 (Register 91, No. 26). New section is current from review by OAL pursuant to Government Code section 11801.


§ 10155. Formal Rating Determinations.
A formal rating determination will be prepared by the Disability Evaluation Unit of the Employment Development Department, based on the information and evidence presented by the employee and the employer. A copy of the formal rating determination shall be served on the employee and the employer, and a copy shall be served on the Administrative Director.


History:
1. New section filed 6-25-91, operative 6-25-91 (Register 91, No. 26). New section is current from review by OAL pursuant to Government Code section 11801.
Appendix F
Page 41

Title 8
Division of Workers’ Compensation

§ 10161

An evaluation shall be performed by a licensed health professional who is experienced in evaluating the physical and vocational capabilities of individuals with disabilities. The evaluation shall be based on comprehensive medical and vocational data. The evaluation shall include a review of the recipient's medical records, vocational history, and any other relevant information. The evaluation shall be conducted in accordance with the standards established by the Division of Workers’ Compensation.

§ 10162

(a) Medical Evaluation

(1) The medical evaluation shall be conducted by a medical examiner or by a licensed health professional who is experienced in evaluating the physical and vocational capabilities of individuals with disabilities. The medical evaluation shall be based on comprehensive medical and vocational data. The medical evaluation shall include a review of the recipient’s medical records, vocational history, and any other relevant information. The medical evaluation shall be conducted in accordance with the standards established by the Division of Workers’ Compensation.

(2) The medical examiner shall prepare a report containing the medical evaluation and any other relevant information. The report shall be submitted to the Division of Workers’ Compensation for review.

(b) Vocational Evaluation

(1) The vocational evaluation shall be conducted by a licensed vocational counselor or by a licensed health professional who is experienced in evaluating the vocational capabilities of individuals with disabilities. The vocational evaluation shall be based on comprehensive vocational data. The vocational evaluation shall include a review of the recipient’s vocational history, educational background, and any other relevant information. The vocational evaluation shall be conducted in accordance with the standards established by the Division of Workers’ Compensation.

(2) The vocational counselor shall prepare a report containing the vocational evaluation and any other relevant information. The report shall be submitted to the Division of Workers’ Compensation for review.

§ 10163

A request for reconsideration of a final decision of the Division of Workers’ Compensation shall be made in accordance with the procedures established by the Division of Workers’ Compensation. The request for reconsideration shall be filed with the Division of Workers’ Compensation within 30 days of the date of the final decision.

§ 10164

The Division of Workers’ Compensation shall issue a decision on the request for reconsideration within 30 days of the date the request is filed. The decision shall be in writing and shall state the reasons for the decision. The decision shall be final unless appeal is filed with the Superior Court within 30 days of the date the decision is issued.

§ 10165

A request for further review of a decision of the Division of Workers’ Compensation shall be made in accordance with the procedures established by the Division of Workers’ Compensation. The request for further review shall be filed with the Division of Workers’ Compensation within 30 days of the date of the decision.

§ 10166

(a) The Division of Workers’ Compensation shall issue a decision on the request for further review within 30 days of the date the request is filed. The decision shall be in writing and shall state the reasons for the decision. The decision shall be final unless appeal is filed with the Superior Court within 30 days of the date the decision is issued.

(b) An appeal from the decision of the Division of Workers’ Compensation shall be made in accordance with the procedures established by the Superior Court. The appeal shall be filed within 30 days of the date the decision is issued.

(c) The Superior Court shall issue a decision on the appeal within 30 days of the date the appeal is filed. The decision shall be in writing and shall state the reasons for the decision. The decision shall be final unless appeal is filed with the Court of Appeals within 30 days of the date the decision is issued.

(d) A request for appellate review of a decision of the Court of Appeals shall be made in accordance with the procedures established by the Court of Appeals. The request for appellate review shall be filed within 30 days of the date the decision is issued.
EMPLOYEE'S PERMANENT DISABILITY QUESTIONNAIRE

To be used for injuries which occur on or after 1/1/91.

This form will aid the doctor in determining your permanent disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

Social Security No.

Employer

Nature of employer's business

Street and Number

City, State, Zip Code

Date of Injury

Date of Birth

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY, using reverse side if needed.

How was your examining doctor selected? (check one)

_____ From a list of doctors provided by the State of California, Industrial Medical Council.

_____ Other (explain)

What is the name of the doctor who will be doing the evaluation?

When is your examination scheduled?

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this disability affect you in your work?

Have you ever had a permanent disability as a result of another injury or illness? _____ If so, when?

Please describe the disability:

Sign here ___________________________ Date: ___________________________

DEU FORM 100 (REV 2/95)

Page 128B.110(c)
REQUEST FOR SUMMARY RATING DETERMINATION
of Qualified or Agreed Medical Examiner's Report

To be used for dates of injury on or after 1/1/71

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:
1. Complete this form and forward it along with a complete copy of all medical reports and medical records
   concerning this case to the physician scheduled to evaluate the existence and extent of permanent disability.
2. If the employee is represented, be sure to send the EMPLOYER'S PERMANENT DISABILITY
   QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
3. This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.

INSTRUCTIONS TO THE PHYSICIAN:
1. If the employee is represented, review and comment upon the Employee's Permanent Disability Questionnaire,
   (DEU Form 100). In your report. If the employee does not have a completed Form 100 at the time of the
   appointment, please provide the form to the employee.
2. Submit your completed medical evaluation and, if the employee is represented, the DEU Form 100, to the
   Disability Evaluation Unit district office listed below. PLEASE USE THIS FORM AS A COVER SHEET FOR
   SUBMISSION TO THE DISABILITY EVALUATION UNIT.
3. If the employee is represented, serve a copy of your report and the Form 100 upon the claims administrator and
   the employee. If the employee is represented, serve a copy of your report on the party or parties requesting the
   evaluation only.

SUBMIT TO: DISABILITY EVALUATION UNIT

PHYSICIAN:

MAILING ADDRESS:

EMPLOYEE

City, State, Zip:

Name:

CLAIMS ADMINISTRATOR

Mailing Address:

Company:

City, State, Zip:

Claim No:

Adjutant:


OCCUPATION:

(Attach a wage statement/SLR 520 if necessary;

Weekly Gross Earnings:

Include the value of additional compensation provided for meals, lodging, etc.

Earnings are irregular or less than 50 hours per week, include a detailed description of all earnings of the employee

from all sources, including other employers, for one year prior to the date of injury.

Benefits will be calculated at

MAXIMUM RATE unless a complete and detailed statement of earnings is attached.

PROOF OF SERVICE BY MAIL:

On , I served a copy of this Request for Summary Rating Determination on

by placing

a true copy enclosed in a sealed envelope with postage fully prepaid and deposited in the U.S. Mail. I

declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature

DEU FORM 101 (REV. 2/95)

Page 1288.10(e)
REQUEST FOR SUMMARY RATING DETERMINATION
of Primary Treating Physician's Report

To be used for injuries which occur on or after January 1, 1994.

INSTRUCTIONS:
1. Complete this form and send it to the Disability Evaluation Unit along with a copy of the primary treating physician's report.
2. This form and any attachments including a copy of the primary treating physician's report must be served on the other party.
3. If you receive the completed form from the other party and you disagree with the description of the occupation or earnings, please attach the correct information to a copy of this form and send it to the Disability Evaluation Unit. You must also send a copy of your objection to the other party.

REQUEST IS MADE BY: ____________________________ PHYSICIAN: ____________________________
Employee
Claims Administrator

CLAIMS ADMINISTRATOR
Company:
Mailing Address:
City, State, Zip:
Claim No.:
Phone No.:

ADJUSTER:

EMPLOYER:

NATURE OF EMPLOYER'S BUSINESS:

JOB TITLE:

DESCRIBE THE GENERAL DUTIES OF THE JOB (Attach job description or job analysis, if available):

WEEKLY GROSS EARNINGS: $ ____________
Attach a wage statement/DLIR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is provided.

PROOF OF SERVICE BY MAIL:
On __________ I served a copy of this Request for Summary Rating Determination on
(date) ____________________________ by placing
(place of employment or claims administrator) ____________________________ (address)
a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature ____________________________

DEU FORM 102 (REV 85)

Page 128A (104)
§ 10161.4. Reproduction of forms.

The Request for Summary Rating Determination (DS-1 Form 101), the Employee's Permanent Disability Questionnaire (DSU Form 150), and the Request for Summary Rating Determination of the primary treating physician (DSU Form 152) may be reproduced by automated office equipment or other means as long as the content is identical to the specified form.

History

1. New section added 4-25-91, operative 4-25-91 (Register 89, No. No.).
§ 10163. Apportionment Referral.
STATE OF CALIFORNIA
Department of Industrial Relations
Department of Workers' Compensation
OFFICE OF BENEFIT DETERMINATION
DISABILITY EVALUATION UNIT

Date: ______________________

TO: Presiding Workers' Comp. Judge.

FROM: Disability Evaluation Unit.

SUBJECT: DEU File;

Employee:

QME:

Date of Report:

The attached formal medical evaluation apportions the permanent disability. Please determine whether the apportionment is valid.

If you refer the report back to the medical evaluator for correction or clarification, and you receive no response within 30 days, please make a determination based on the available evidence.

Please indicate whether the apportionment is consistent with the law by checking the appropriate space, sign and date the bottom of this form and return it with the medical report to the DEU office listed above.

Thank you.

The apportionment IS CONSISTENT _______ or IS NOT CONSISTENT _______ with the law.

(Signature)

Workers' Compensation Judge

(Data)

NOTE: This memorandum is an administrative document and is not admissible in any judicial proceeding.

DEU form 106 (Rev 3-91)


History:
1. New section filed 4-15-91, effective 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL, pursuant to Government Code section 12884.
§ 10164. Summary Rating Determinations.

Reconsideration of Employee's Unrepresented.

(a) Requests for reconsideration of the summary rating determination must be filed with the Administrative Director in writing within 30 days of receipt of the summary rating determination. The request shall clearly specify the reasons the summary rating determination should be reconsidered and shall be accompanied by a copy of the summary rating, a copy of the comprehensive medical evaluation, proof of service on the other party and any other information necessary to support the request. Reconsideration of a summary rating may be granted by the administrative director for one or more of the following reasons:

(1) The summary rating was incorrectly calculated.
(2) The comprehensive medical evaluation failed to address one or more issues;
(3) The comprehensive medical evaluation failed to address one or more issues;
(4) The comprehensive medical evaluation was not prepared in accordance with required procedures, including the procedures of the Industrial Medical Council promulgated under paragraph (2) of subdivision (5) of Section 119.2.

Requests for reconsideration which are not based on one or more of the above issues will be denied.

(b) The Administrative Director shall not accept or consider, as a basis for a request for reconsideration, a supplemental or follow-up evaluation which was requested by a party after the summary rating determination but already been issued to the parties.

(c) If the Administrative Director determines that an additional evaluation from another Qualified Medical Examiner is necessary, the matter shall be referred to the Executive Medical Director of the Industrial Medical Council for the provision of another Qualified Medical Examiner.


History:
1. New section filed 4-25-91, operative 4-25-91 (Register 91, No. 26). New section in except form prior to OAL renumber Government Code section 1321.
2. Amendment of section filed 1-26-94, operative 1-26-94. Submitted to OAL for printing only pursuant to Government Code section 1321 (Register 94, No. 4).
3. Amendment of section adding, renumbering subdivision (a), subdivision (b), renumbering subdivision (c), and (f) and amendments of subdivision (d) to be effective January 26, 1994, operative 1-26-94. Submitted to OAL for printing only pursuant to Government Code section 1321 (Register 94, No. 4).

§ 10166. Service of Summary Rating Determination and Notice of Options Following Permanent Disability Rating.

Within the time specified in Labor Code section 4061(b), the Office of Benefits Determination shall serve the permanent disability rating determination on the employee and employer by first class mail. At the same time, the employee shall also be served with the Notice of Options Following Permanent Disability Rating.


History:
1. New section filed 4-25-91, operative 4-25-91 (Register 91, No. 26). New section in except form prior to OAL renumber Government Code section 1321.
§ 10165.5. Form (Notice of Options Following Permanent Disability Rating).

NOTICE OF OPTIONS FOLLOWING PERMANENT DISABILITY RATING

This is a permanent disability rating determination (Rating) prepared by the State of California Disability Evaluation Unit within the Division of Workers' Compensation. It describes your percentage of permanent disability. This percentage is based on your limitations as reported by the doctor, your age, and the type of work you were doing at the time of your injury. If the rating indicates that you have some permanent disability, you should automatically begin to receive permanent disability payments. Payments are made in installments, every two weeks, for the number of weeks shown on the rating, less any permanent disability payments made to you prior to the rating.

If the rating is not disputed by you or your employer, you do not have to take any action to receive your benefits. We do want you to know that you may have two options you may want to consider. They are:

1) STIPULATED FINDINGS AND AWARD;
2) COMPROMISE AND RELEASE.

1) STIPULATED FINDINGS AND AWARD

If you and the employer, carrier or agent accept the rating, written agreements may be submitted to the Workers’ Compensation Appeals Board (WCAB) requesting that an Award be made without the need for a hearing. We recommend this option when the rating is not disputed, and you have a need for future medical care. A Workers’ Compensation Judge will review the stipulations and issue an award.

ADVANTAGES

- A stipulated award is a quick, easy way to settle your case while protecting your rights;
- There is no need to take time off work to go to a hearing;
- The Division of Workers’ Compensation will review the settlement to protect your rights at no cost to you, there is no need to hire a lawyer;
- If your condition worsens, you can apply for additional payments anytime within five years from the date of your injury;
- If you need additional medical care or you are to receive a life pension (rating of 70% or more), your rights to future benefits can be fully protected and a judge can enforce the award if there later becomes a problem.
- You may request a lump sum payment of all or part of your permanent disability if you can show a financial need or hardship. However, a Workers’ Compensation Judge must first be convinced that it would be in your best interest.

DISADVANTAGES

- You normally will not receive a lump sum payment, but will receive your benefits in payments every two weeks.
2) COMPROMISE AND RELEASE

A Compromise and Release Agreement is a settlement which usually permanently closes all aspects of a workers' compensation claim except for vocational rehabilitation benefits, including any provision for future medical care.

The Compromise and Release is paid in one lump sum to you. It must be reviewed and approved by a Workers' Compensation Judge.

ADVANTAGES

• You may receive more money than you would receive under a Stipulated Findings and Award because you are giving up your future rights for a lump sum settlement.

• If the employer or insurance company disputes the rating, a Compromise and Release will assure you receive a larger lump sum amount rather than risk getting nothing or a lesser amount later.

• You will receive your benefits in one lump sum.

DISADVANTAGES

• A Compromise and Release usually permanently releases the employer from all future responsibilities. After your case has been resolved by a Compromise and Release Agreement, you cannot ask for more medical treatment at your employer's expense, nor can you claim additional benefits if your disability or condition becomes worse. Also, if you later die as result of the injury, your dependents would not be entitled to death benefits.

• Once a Workers' Compensation Judge has approved your Compromise and Release, the settlement is final and it cannot be set aside except in very rare circumstances.

If you would like more information, you can receive recorded information free of charge, by calling 1-800-736-7401 or you may contact your local Information and Assistance Officer listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. You may also consult an attorney of your choice.

SPECIAL NOTICE TO UNREPRESENTED INJURED WORKERS

If you disagree with the rating because the doctor failed to address any or all issues or failed to follow the procedures of the Industrial Medical Council, you may request reconsideration of the rating from the Administrative Director of the Division of Workers' Compensation. In some cases, you may be entitled to an additional medical evaluation or a different medical specialist.

Your request should include a copy of the rating and a copy of the report from the doctor. A copy of the request must be sent to your claims adjustor.

If you have questions about whether to request reconsideration of your rating or whether another medical evaluation is appropriate, you should contact the local Information and Assistance Officer listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. They can tell you how to file the request if you decide to do so.

DEU FORM 110 (Rev. 1/96)
**Appendix F**

**Subchapter 1.7**

**§ 10175. Definitions.**

**Subsection 2.**

- **(d) Employer** means any person defined as an employer in Section 3000 of the Labor Code who has secured the payment of workers' compensation benefits as required by Section 3000 of the Labor Code.
- **(e) Exclusivity provision** means an option chosen by an employee under Section 6300, under which medical, surgical, and hospital treatment for both occupational and non-occupational injuries and illnesses are provided to the employee through a health care service plan.
- **(g) Health care service plan** means any of the following which offer a managed care product:
  1. A health care service plan licensed under Section 1387 of the Health and Safety Code (Koch-Keene Health Care Service Plan Act).
  3. An insurance policy or certificate of insurance providing group health care coverage as defined in Section 1387 of the Health and Safety Code.
  4. An option selected by an employee under Section 6300, under which medical, surgical, and hospital treatment for both occupational and non-occupational injuries and illnesses are provided to the employee through a health care service plan.
  5. Multi-employer collectively bargained employee welfare benefit plan or an employee welfare benefit plan sponsored by a recognized exclusive bargaining agent for State employees.
8.1017. Eligible Employers and Employees.

(a) Employers whose principal place of business is in any of the following counties may participate in the pilot project:
   (1) Los Angeles
   (2) San Diego
   (3) Santa Clara
   (4) Sacramento

(b) Employees of employers eligible to participate in the pilot project are eligible to participate in the pilot project:
   (1) If an employee is employed in a county other than those enumerated in subdivisions (a), the employee is not prevented from participating in the project.
   (2) Nothing in this section shall be construed to prohibit participation by employees whose principal place of business is not within one of the first counties listed in subdivision (a) above if the employer is specifically authorized to do so by statute.

THE CALIFORNIA STATE UNIVERSITY

BRIEF DESCRIPTION OF THE REHABILITATION PROCESS

I. **Eligibility**

An employee shall be eligible for vocational rehabilitation services provided:

A.) The employee is incapable of returning to the full duties of his/her former job without rehabilitation services because of a permanent, disabling condition;

B.) The individual has sufficient potential to benefit from the rehabilitation process;

C.) The employee, on a voluntary basis, is willing to participate in rehabilitation planning;

D.) The medical prognosis is compatible with rehabilitation planning.

II. **Diagnostic Work-Up**

The first step in the rehabilitation process is the diagnostic work-up. This work-up involves the development of appropriate social, psychological, economic, and medical information. This information is needed as a basis for sound vocational planning.

III. **The Planning Process**

A.) **The Employer**

The employer is a very important resource in the planning process. The employer often has a great deal of information about the employee which may provide substantial help in the development of a new type of job environment for the employee. Some of the knowledge which the employer has includes:

1.) Long term contact with the employee which provides knowledge of the employee's performance and potential;

2.) Knowledge about how the employee relates to supervisory staff and colleagues;
3.) Knowledge about the employee's attendance patterns;

4.) Knowledge about the ability of the campus to assist the employee in one or more of the following ways:
   - Transfer
   - Place on leave
   - Reasonable accommodation
   - Offer special training
   - Develop a training and development assignment.

B.) The Rehabilitation Counselor

The counselor working with the employer may identify a number of possibilities for new training and placement for the employee. The counselor utilizes those services which will meet the individual need of the particular employee. While the range of services are quite extensive, the major services s/he utilizes are:

1.) Counseling with the employee;
2.) Retraining utilizing colleges, business schools, tutoring, or on-the-job training;
3.) Job placement;
4.) Physical restoration services;
5.) A variety of other services which may include supplemental maintenance, allowance for transportation, books and supplies, tools, stocks and supplies for self employment.

C.) The State Fund Claims Representative

The claims representative, on industrial cases, is the primary contact for arranging immediate service to the disabled employee. His/her focus is to ensure that your employee:

1.) Has suitable medical treatment;
2.) Returns to employment as soon as possible;
3.) If rehabilitation is necessary, it is provided to the employee;
4.) The employer and the employee receive attention with respect to the litigation process in those cases where litigation is necessary.
The supervisor or manager should have access to the claims representative on any case where there appears to be a misunderstanding or where the employer has need for additional information about the employee who is injured.

D. The Employee

Each employee referred for rehabilitation services will be evaluated for rehabilitation services in terms of his/her:

1.) Age  
2.) Marital status  
3.) Education  
4.) Vocational experience  
5.) Aveocation  
6.) Motivation  
7.) Level of confidence  
8.) Willingness to change  
9.) Ability to relate to people  
10.) Degree of disability  
11.) Economic status  
12.) Eligibility for other plans (these plans include Social Security, retirement, Workers' Compensation, private health insurance, private disability insurance, welfare, veteran's benefits, and previous retirement).

IV. Placement

The employee who has been trained may be placed in an area of work compatible with his/her training, and one that will not interfere with his/her medical limitations. Whether or not the employee returns to the former employer will depend on the employer's willingness and capacity to utilize the employee. At such time as the employee has successfully completed the rehabilitation program, the employer will take at least one of the following actions:

A.) Restore the employee to his/her former position if s/he is able to perform such duties. If the employee is covered by the Americans with Disabilities Act (ADA), restore the employee to his/her former position if s/he is able to perform the essential duties of the position with or without accommodation.

B.) Demote or transfer the employee to another position. If the employee is covered by the ADA, demote or transfer the employee to another position if s/he is able to perform the
essential duties of the position with or without reasonable accommodation.

C) Place the employee on a training and development assignment in another line of work with intent to transfer at a later date.

If employment is not possible with any department, the employee may be placed with a private employer, or if s/he has special skills, in his/her own business.

Summary

The above information gives you an overview of some of the elements in the rehabilitation process. The employer is a key person in the rehabilitation process of the employee. The employer has available a great deal of valuable information which can be utilized to effectively assist the employee's return to the competitive labor market.
THE CALIFORNIA STATE UNIVERSITY
THE EMPLOYEE INDUSTRIAL DISABILITY CLAIM PROCESS

Injured employee (EE) reports injury to Supervisor. Request employee claim form (SCIF 3301).

Supervisor arranges for first aid and transportation to and treatment by physician, if necessary. Provides employee claim form.

Supervisor prepares Standard Form 620 "Supervisor's Injury Prevention Report" (as back of Form 3067) and forwards to W/C Administrator and physician.

W/C Administrator or Personnel Office prepares SCIF Form 3067, "Employee's Report of Occupational Injury or Illness" and forwards to SCIF together with employee claim form.

Return to Work Coordinator maintains contact with disabled EE during disability period.

SCIF verifies eligibility for compensation of EE and notifies employer on SCIF Form 3290 "Temporary Disability Verification of State Employees."

If ineligible, EE may initiate formal hearing appeal.

If eligible, CSU sends to EE Standard Forms 618, "Disability Benefit Selection Card" and 619, "Industrial Disability Benefits Information," and to both EE and Personnel Office SCIF 3009, "Benefit Information Letter."

Return to Work Coordinator arranges counseling of the disabled EE to establish whether TD or IDL is desired or applicable.

EE selects choice of benefits and sends Standard Form 618 to Personnel Office within 15 days of the postmark date.

Employer sends SCIF Form 3068 to SCIF, Payroll and EE's file to record decision on Temporary Disability (TD) vs. IDL.

If IDL chosen, campus Payroll notifies State Controller's Office with Standard Form 674 at end of each pay period. Employee must find out within 15 days if employee desires supplementation using available sick leave credits. Employee will not be allowed IDL with supplementation unless it is requested.

If TD chosen, employee must find out within 15 days if EE desires supplementation using available leave credits-supplementation will be automatic if EE fails to respond within 15 days. SCIF handles TD payment.