



LOS ANGELES UNIFIED SCHOOL DISTRICT POLICY BULLETIN

TITLE: Act of Violence

NUMBER: BUL-1603

ISSUER: David Holmquist, Director,
Risk Management and Insurance Services

DATE: September 8, 2005

ROUTING

LD Superintendents
 All Local Districts
 Support Directors
 All Schools and
 Locations
 Administrators
 Managers
 Supervisors
 School
 Administrative Asst.

POLICY: Act of Violence Guidelines

MAJOR CHANGES: This revision replaces Bulletin No. S-11, dated December 16, 2002. The content has been revised to reflect changes to forms, contacts and processing procedures. Please discard old forms and replace them with the new ones.

- Attachments at the end of this bulletin are:
- A - Workers' Compensation Claim Form (DWC 1)
 - B – Benefits and Responsibilities of Employees Injured as a Result of an AOV
 - C – Special Physical Injury/Alleged Act of Violence Report (AOV-1 Rev. 1/05)
 - D – Workers' Compensation Injury Report Worksheet
 - E – LAUSD Incident Report Form

RELATED RESOURCES: Refer to Workers Compensation Procedures (REF -1279)

GUIDELINES: The following guidelines apply.

I. INTRODUCTION

An act of violence injury is a physical injury to an employee resulting from an intentional, violent act that occurred during the performance of assigned duties. Determination that the injury was a direct result of an act of violence will be made by the site administrator in conjunction with Risk Management and Insurance Services.

II. RESPONSIBILITIES OF SITE ADMINISTRATOR

- A. When an act of violence is reported, the site administrator or designee shall:
1. If employee is seriously injured, call 911 for paramedics or other emergency services to transport the employee to the nearest hospital.
 2. If the injury is not a serious one, have an on-site school nurse (if available) or other qualified person provide first aid.



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3. An employee requiring treatment beyond first aid, but who does not require emergency medical treatment, should be referred to a member of the District's Medical Provider Network.
4. The site administrator should report the incident immediately to the School Police Department for investigation. If the employee involved is a member of UTLA, the Chapter Chair should also be notified, unless the employee requests that the notification not be made.
5. The site administrator or designee should immediately provide the injured employee with:
 - a) State of California "Employee's Claim for Workers' Compensation Benefits Form" (DWC 1, Attachment A) after completing the employer's section.
 - b) A copy of "Benefits and Responsibilities of Employee Injured as a Result of an Act of Violence" form (Attachment B). Retain a signed copy.
 - c) The "Special Physical Injury/Alleged Act of Violence Report", (Attachment C). Have the employee complete Section 1.

NOTE: If the employee is unable to receive the forms at the time of injury, the site administrator should mail them to the employee's home address.

6. Complete the "Workers' Compensation Injury Report Worksheet" (Attachment D) and report the injury to Sedgwick Claims Management Services, Inc., within 24 hours by calling 1-800-LAUDWC. Maintain the form on file at the work site.
7. Complete the employer section of the "Special Physical Injury/Alleged Act of Violence Report" (Attachment C) which will be used by the Site Administrator to determine whether or not an act of violence has occurred. If necessary, contact Risk Management and Insurance Services Division for assistance in making this determination.
8. Promptly investigate the incident to determine whether the incident was or was not an act of violence as defined in the appropriate bargaining unit agreement.
9. Inform the local district office or division administrator of the incident
10. If the incident involves a violent act committed by a student, appropriate disciplinary action should be taken.
11. Complete the LAUSD Incident Report Form (Attachment E) and distribute as indicated on the form.

NOTE: THE LAUSD INCIDENT REPORT FORM MUST BE COMPLETED WHETHER OR NOT THE INCIDENT IS DEEMED AN ACT OF VIOLENCE.

12. Forward copies of the act of violence reporting forms to the Office of Risk Management and Insurance Services, Workers' Compensation department.
 - a. Obtain medical certification for absences due to the act of violence.
 - b. If it is anticipated that a leave of absence will become necessary and that it will exceed 20 working days, refer the injured employee to the appropriate Personnel Office to obtain applicable leave of absence forms.
 - c. Maintain on-going contact and offer assistance to the injured employee.
- B. If an incident occurs on District premises other than the employee's regular assignment, the off-site administrator shall assume the responsibilities indicated above and:
 1. Inform the injured employee's regular site administrator regarding the incident.



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2. Distribute reports as required and forward copies to the injured employee's site administrator.

C. The injured employee's site administrator shall:

1. Review the report submitted by the off-site administrator or designee.
2. Verify that all required reports and notifications have been processed.
3. Assume responsibility for items 11 and 11. a – c above.

III. PAYROLL REPORTING PROCEDURE

The time reporter shall enter payroll code "WC" on the employee's timecard for each date of absence attributed to the injury and write in the remarks section, "act of violence."

THE TIME REPORTER SHALL CONTACT THE APPROPRIATE PAYROLL CLERK FOR PAYROLL ADJUSTMENT INSTRUCTIONS.

IV. INSTRUCTIONS TO INJURED EMPLOYEE

A. The injured employee shall review "Benefits and Responsibilities of Employees Injured as a Result of an Act of Violence" (Attachment B) and follow all instructions.

V. DAY-TO-DAY SUBSTITUTES AND TEMPORARY EMPLOYEES

When the injured employee is a day-to-day substitute or temporary employee, the administrator at the site where the incident/injury occurred is responsible for completing the injury reporting process and must forward a complete set of the injury reports to the Certificated Substitute Unit for certificated employees or to Classified Personnel Assignments for classified employees.

For assistance or further information please contact the Office of Risk Management and Insurance Services, Workers Compensation Specialist at 213-241-3966.

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your pre-designated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-Primary Treating Physician PTP es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o después de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento aplicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares (\$10,000).

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de

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Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to the DWC web site at www.dir.ca.gov. Link to Workers' Compensation.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de noche, o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atiende, el/la administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapacidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitos, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapacidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despidan, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Código Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador (*Division of Workers' Compensation - DWC*), o puede escuchar información grabada, así como una lista de oficinas locales, llamando al (800) 736-7401. Ud. también puede ir al sitio electrónico en el Internet de la DWC en www.dir.ca.gov. Enlázese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California (*State Bar*) al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en www.californiaspecialist.org.



WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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

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

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

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above Empleado—complete esta sección y note la notación arriba.

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____

6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* _____

7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____

15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Employer copy/Copia del Empleador Employee copy/ Copia del Empleado

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Claims Administrator/Administrador de Reclamos Temporary Receipt/Recibo del Empleado



ACCIDENT/INCIDENT INVESTIGATION REPORT

Use of this form is required for all incidents involving personal injury, property damage or "near misses" (incidents which could have resulted in injury or damage). This is a **CONFIDENTIAL REPORT** for transmission to and use by attorneys for the Los Angeles Unified School District.

1. INCIDENT TYPE¹ (check all that apply)

Student Injury/Illness Employee Injury/Illness Visitor Injury/Illness Property Damage Near Miss Other

2. INCIDENT INFORMATION

Date/Time of Incident _____ Date/Time Reported _____ Parent/Guardian Notified _____

Did incident occur on District property? Yes Office or School Name _____ Location Code _____

No²

Description of Injury or Property Damage: _____

Description of Incident (What was the injured party doing at the time of the incident? Describe the events immediately preceding the incident. Identify names of any LAUSD employees involved in the incident, and any tools, machinery, equipment, or vehicle involved in the incident. Attach photos)

Name(s) and Phone Numbers of Witness(es) (attach statement of each witness)

3. INJURED PARTY INFORMATION³ (separate report must be completed for each injured party)

Name Injured Party _____ Home Address _____

City _____ Zip _____ Home Telephone # () _____

Sex Male Female Date of Birth / / Employee Location Code _____ Employee Number _____

4. RESPONSIBLE PARTIES⁴

Name _____ Home Address _____

City _____ Zip _____ Home Telephone # () _____

Physical Description _____ Was an arrest made? Yes No

5. MEDICAL TREATMENT

Was first aid administered? Yes No If so, provide name of person _____

Did supervisor/employee accompany injured party to hospital/clinic? Yes No Initial treatment received _____

Doctor's recommendation: Temporary Disability Return to Full Duty Unknown Restricted Duty _____

Doctor's Name _____ Medical Facility _____ Telephone No. () _____

6. FINDINGS AND CONCLUSIONS

Key Findings⁵

Conclusion⁶

ACCIDENT/INCIDENT INVESTIGATION REPORT

Was this incident a result of an: Unsafe Act? Unsafe Condition? Neither

Describe 'Unsafe Act' and/or "Unsafe Condition": _____

Actions Taken to prevent accident recurrence: _____

Related/Attached Reports: _____

7. RECOMMENDATIONS/ADMINISTRATIVE FOLLOW-UP

List recommendations and/or administrative follow-up:

Required Referrals:

Was this a "serious injury" ⁷ to employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, contact Cal/OSHA at (213) 576-7451.
Was DWC-1 Form provided to employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to Sedgwick CMS at (800) LAUSD-WC.
Was this a "serious injury" ¹ to a third party?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to ORMIS at (213) 241-3127.
Were injured parties hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to ORMIS at (213) 241-3127.
Did the incident involve a possible act of violence ⁸ ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to School Police at (213) 625-6631 and ORMIS at (213) 241-3139. Contact Youth Relations at (213) 745-1990 for student violence
Is employee discipline under consideration?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to Staff Relations at (213) 241-6056.
Does the incident involve evidence of child abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to Child Protective Services at (800) 540-4000.
Were students or staff traumatized?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to Site Crisis Team.
Did an unsafe condition contribute to this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, place "Trouble Call" at (213) 745-1600.
Did the accident involve hazardous substance release?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to OEHS at (213) 241-3199.
Did the accident involve vandalism?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to School Police at (213) 625-6631.
Was District property damaged by third party?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, refer to ORMIS at (213) 241-3127.

8. SIGNATURES *(By signing this document, both the Supervisor and Site Administrator agree to protect this document against unlawful distribution.)*

<i>Signature of Preparer</i>	<i>Employee No.</i>	<i>Date</i>	<i>Signature of Site Administrator</i>	<i>Employee No.</i>	<i>Date</i>
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9. INSTRUCTIONS *(For completing Sections 1 through 8)*

¹ This report must be completed for all incidents involving personal injury, property damage or "near misses" (incidents which could have resulted in injury or damage) within 24 hours of an incident. Copies of this report must be sent to OEHS and ORMIS and retained at the site.

² If the accident occurred off-site, please indicate location, including address, city and zip code.

³ All employee injuries requiring more than first aid must be reported to Sedgwick CMS at (800) LAUSD-WC within 24 hours.

⁴ Responsible Parties: Other persons that caused or contributed to the injury.

⁵ "Key findings" are factual information that contributed to the accident, for example a forklift driver was driving too fast and did not complete his training.

⁶ Conclusions are determination or result of the accident investigation, for example the supervisor failed to ensure the forklift driver completed the required training.

⁷ Cal/OSHA defines a "serious injury" as a death, amputation, permanent disfigurement, hospitalization for more than 24 hours for other than observation, or an incident resulting in multiple injuries requiring hospitalization. You are required to notify Cal/OSHA within 8 hours at one of the following numbers: Pico Rivera (562) 949-7827; Los Angeles (213) 576-7451; Torrance (310) 516-3734; or Van Nuys (818) 901-5403. All cases involving "serious injury" to visitors must be referred to School Police at (213) 625-6631. Employee injuries in which fraud is suspected should be referred to the Sedgwick CMS Fraud Unit at (626) 397-9272. Other suspected fraud cases should be referred to the OIG at (866) LAUSD-OIG.

⁸ An act of violence may involve student vs. student or student vs. teacher. The School Site Crisis Team should be notified when students or staff are traumatized. All cases involving possible acts of violence must be referred to School Police at (213) 625-6631.

COPIES TO: (1) OFFICE FILE	(2) OFFICE OF ENVIRONMENTAL HEALTH & SAFETY	(3) OFFICE OF RISK MANAGEMENT & INSURANCE SERVICES
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LOS ANGELES UNIFIED SCHOOL DISTRICT
OFFICE OF RISK MANAGEMENT AND INSURANCE SERVICES

Special Physical Injury/Alleged Act of Violence Report
(To Be Completed by the Site Administrator or Designee and Injured Employee)

SECTION 1. (To be completed by employee)

Employee Name: Last First Middle Employee Number

Home Address: Street City Zip (Area) Telephone No.

School/ Site Name District/Div. (Area) Telephone No. Date of Incident Time

Describe in detail how incident/injury occurred (You may attach additional information on separate sheet of paper):

Location where alleged act of violence occurred:

Nature of Injury/Illness and part(s) of body affected:

Incident reported to school police? Yes No Date Reported:

Name of School Police Officer:

Was another person responsible for injury? Yes No If yes provide identifying information below.

Was this with intent to harm? Yes No

Name: Address: Telephone No. :

Employee Signature: Date:

SECTION 2. (To be completed by Site Administrator or designee)

Employee was provided with a copy of the "Benefits and Responsibilities of Employee Injured As a Result of an Act of Violence" form: Yes No

I concur with the description detailed above : Yes No -- If you do not concur, state reason why:

(Attach additional sheet of paper if necessary)

ADMINISTRATOR DETERMINATION:

Site Administrator Name (PRINT) Telephone No. Date

I CERTIFY BY MY SIGNATURE THAT TO THE BEST OF MY KNOWLEDGE, AN ACT OF VIOLENCE:

DID NOT OCCUR DID OCCUR

Site Administrator Signature

DISTRIBUTION:

- Work Site-White School Police-Pink
DORMIS W/C-Yellow Payroll-Goldenrod
Sedgwick CMS-Green Employee-Blue

**Los Angeles Unified School District
Workers' Compensation Injury Report Worksheet
Call 1-800-LAUDWC**

Employee's Assigned Location	Location Code
Date of Incident	Time of Incident : AM/ PM
Date Incident Reported to District	Time Incident Reported to District : AM/ PM
Caller's Name/Title	Caller's Phone Number

Claimant Information

Employee ID #	Employee Name
Employee SS #	Home Address
Work Phone	
Home Phone	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Employee Title	Date of Birth / / mm/dd/yyyy
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>	Date of Hire / / mm/dd/yyyy
Average number of hrs per day M T W Th F Sa Su	Date of Termination (If Any) / / mm/dd/yyyy
Supervisor's Name/Title	Supervisor's Phone Number

Incident Information

Description of Incident	
Cause of Incident (lifting, slip and fall, etc.)	Primary Body Part Injured (lower back, left/right hand, etc.)
Nature of Incident (strain, burn, fracture, etc.)	Was Medical Treatment Received <input type="checkbox"/> Y <input type="checkbox"/> N Did employee go to the Emergency Room <input type="checkbox"/> Y <input type="checkbox"/> N
Medical Provider Information (If Applicable)	Name of Hospital/Clinic
Name of Doctor	Address of Hospital/Clinic
Phone Number	
Incident Location (If different from Employee's Assigned Location)	
Witness Name/Phone Number	Witness Name/Phone Number

State Information

State Unemployment Insurance Account Number 942-5052	Date an Employee Claim Form was provided to employee
Location where incident or exposure occurred (classroom, cafeteria, etc.)	Were other employees injured/ill in this event?
Equipment, materials, and chemicals that the claimant was using when the incident or exposure occurred	Specific activity the claimant was performing when the incident or exposure occurred

Additional Information

Name and Title of whom the incident was first reported?
Was there medical treatment beyond First Aid?
Did the employee lose consciousness?
Did a health care professional diagnose a significant injury or illness?
Did the injury or illness involve a needle stick from a contaminated needle?
Was the employee hospitalized overnight as an in-patient?
What time did employee begin work?

LOS ANGELES UNIFIED SCHOOL DISTRICT

BENEFITS AND RESPONSIBILITIES OF EMPLOYEE INJURED AS A RESULT OF AN ACT OR ACTS OF VIOLENCE

1. An employee physically injured as a result of an Act of Violence which arises out of his/her District employment may be eligible for salary continuance if the injury is accepted as industrial by the District's workers' compensation administrator. Determination as to whether or not the physical injury was the direct result of an Act of Violence shall be made by the Site Administrator in consultation with the Risk Management and Insurance Services Division.

Such salary continuation begins on the first day of absence due to the Act of Violence and shall not extend beyond the last day for which workers' compensation temporary total disability is paid.

2. During this period of absence, the employee's salary will be paid in accordance with the following provisions.
 - A. The District shall issue a salary warrant to the employee for regular salary; the amount of the payment attributed to the total temporary disability benefit will be identified on the pay stub.
 - B. An employee in substitute, temporary, or limited adult teaching status shall be granted paid absence based on the assignment and salary to which he/she is entitled at the time of the injury, but no less than the employee's average weekly earnings as determined for workers' compensation purposes.
 - C. A limited term employee serving under a written contract may receive paid leave only during the term of the contract period.
3. If an injured employee is unable to return to his/her regular position with the District, the employee may submit a request for temporary modified duties or reasonable accommodation. Information and an application may be obtained by contacting the Integrated Disability Management Department at 213-241-3974.
4. Employees with at least five years of service who are incapable of returning to work may apply for disability retirement with the State Teachers Retirement System or the Public Employees Retirement System.

EMPLOYEE RESPONSIBILITIES

- A. To ensure immediate investigation into the circumstances surrounding the incident reported, the employee must report an Act of Violence to the site administrator.
- B. The Employee Section of “Special Physical Injury/Alleged Act of Violence Report” (Form AOV-1 Rev. 1/05, Attachment C) must be completed by the employee and submitted to the site administrator as soon as possible, preferably within 24 hours.
- C. As soon as is medically possible, the employee must see a District-approved medical provider.
- D. If the absence will extend beyond 20 working days, the usual requirements regarding leave of absence will apply. Leave of absence forms may be obtained from the appropriate Human Resources office.
- E. An extension of leave beyond the initial period requested is dependent on continued temporary total disability under the District’s workers’ compensation program. New leave forms and Attending Physician’s Statements are required for subsequent leave extensions.
- F. If needed, an Act of Violence leave may be extended by submitting the appropriate District form and medical verification of the necessity for the extension to the Workers Compensation Department for approval.
- G. Substitute or temporary employees shall also follow all the procedures indicated above.

(A signed copy of this form must be given to the employee and the original retained by the site)

EMPLOYEE SIGNATURE:	EMPLOYEE NO.	DATE

The administrator’s signature of this form serves as verification that the employee received a copy.

ADMINISTRATOR SIGNATURE:	PRINT NAME	DATE