North Valley Animal Disaster Group Standard Operating Guidelines

Title: DISASTER SERVICE WORKER (DSW)

Objective: To provide a brief description of the Disaster Service Worker Program

Description:

NVADG is recognized by the Butte County Disaster Council for the purpose of engaging in disaster service pursuant to the California Emergency Services Act. Volunteers who meet the requirements are registered Disaster Service Workers (DSW). One of the biggest advantages of being a DSW is that the volunteer is covered by Worker's Compensation Insurance during deployments and recognized trainings.

- Disaster service means all activities authorized by and carried on pursuant to the California Emergency Services Act while assisting any unit of the emergency organization, including approved, documented and supervised; activities performed to mitigate an imminent threat of extreme peril to life, property and resources, and training necessary to engage in such activities.
- To qualify as DSW training, an annual schedule of training events must be submitted to the Butte County Public Health by January 31 of each year. Additional training can be approved by contacting Butte County Public Health prior to the training.

Volunteers of NVADG are registered Disaster Service Workers, and covered by workers compensation insurance during incidents and training if all the following is met:

- Application is completed.
- A signed statement that the loyalty oath or affirmation was taken or subscribed before an officer authorized to administer oaths.

Note: in the event of an injury, the volunteer and his/her leader will follow the Butte County Disaster Council's DSW Volunteer Injury and Recordkeeping requirements. Refer to the attached Disaster Service Worker Volunteer Policy for additional information and protocols.

Disaster Service Worker Volunteer Policy
Butte County, California

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1. **Purpose**

Butte County's Disaster Service Worker (DSW) Volunteer program is designed to coordinate and manage all volunteer efforts which support services provided to the community. The program addresses community service needs, while placing special emphasis on Butte County's priorities.

2. **Scope**

This policy applies to all Butte County volunteers registered as a Disaster Service Worker Volunteer as defined in section 3.

3. **Definition of Disaster Service Worker Volunteer**

For the purpose of Workers' Compensation and this policy, a Disaster Service Worker Volunteer is defined as:

- Any person registered with an accredited Disaster Council or the California Governor's Office of Emergency Services or a state agency granted authority to register Disaster Service Worker Volunteers, for the purpose of engaging in disaster service pursuant to the California Emergency Services Act without pay or other consideration.
- Public employees, performing disaster work outside their regular employment without pay, and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.
  <u>Exclusions:</u>
  - Disaster Service Worker Volunteer does not include any member registered as an active fire fighting member of any regularly organized volunteer fire department, having official recognition, and full or partial support of the county, city, town or district in which such fire department is located.
  - The individual is sponsored by an outside agency and provides services through that sponsoring agency.
  - Example: Red Cross volunteers

4. **Definition of Accredited Disaster Council**

A Disaster Council may become accredited through certification by the California Governor's Office of Emergency Services when the Disaster Council agrees to follow and comply with the rules and regulations established by the California Governor's Office of Emergency Services pursuant to the

provisions of the Emergency Services Act. The Butte County Disaster Council was accredited on December 19, 1946.

5. Definition of Disaster Service

Disaster service means all activities authorized by and carried on pursuant to the California Emergency Services Act while assisting any unit of the emergency organization during a proclaimed emergency or during a Search and Rescue mission, including approved, documented and supervised:

- Activities performed to mitigate an imminent threat of extreme peril to life, property and resources, and
- Training necessary to engage in such activities.

Such activities are under the general direction of the accredited Disaster Council (or designated agency or authority) including how supervision will be performed (i.e. onsite, offsite) and who will act in a supervisory capacity, (i.e. paid staff, volunteers). It is the responsibility of the accredited Disaster Council (or designated agency or authority) that only persons with appropriate supervisory skills, as determined by the accredited Disaster Council (or designated agency or authority), act in a supervisory capacity.

Exclusions. Disaster service does not include any activities or functions performed by a person if the accredited Disaster Council with which the person is registered receives a fee or other compensation for the performance of that person's activities or functions.

6. Training

For purposes of this policy, training is a pre-authorized activity sponsored by an accredited Disaster Council (or designated agency or authority) and may include classroom instruction, disaster drills or exercises, or related activities designed to enhance the disaster response skills (including safety) of the Disaster Service Worker Volunteer. Out-of-state training conducted in a manner geographically and functionally specific to cross-border emergency response may also be considered a covered activity.

By January 31st of each year, volunteer groups shall submit an annual training schedule for the upcoming year with planned activities to include the type of training, training location, estimated date of training and training supervisor. All trainings shall include a sign in roster to be submitted upon completion of training. As trainings are added throughout the year, they will be submitted in advance to Butte County. Sheriff's Comm Reserve and Search and Rescue will submit calendars and sign in rosters to the Butte County Sheriff's Office. The North Valley Animal Disaster Group will submit calendars and sign in rosters to Butte County Animal Control. All other volunteer groups will submit calendars and sign in rosters to Butte County Office of Emergency Management (OEM). Such activities are under the general direction of the accredited Disaster Council (or designated agency or authority) including how supervision will

be performed (i.e. onsite, offsite) and who will act in a supervisory capacity, (i.e. paid staff, volunteers).

Exclusions. Unless the volunteer is directly providing disaster services, activities that are not covered under workers' compensation coverage include, but are not limited to, parades, public exhibitions, physical fitness training, out-of-state training not conducted in a manner geographically and functionally specific to cross-border emergency response or other training activities not related to disaster service.

7. Registration

A person shall be deemed to be registered if the following information is on file with Butte County: a) Name of registrant;

b) Address of registrant;

c) Date enrolled (established as the date the loyalty oath is administered);

d) Name of registering government agency or jurisdiction with signature and title of authorized person;

e) Classification of disaster service, as defined in section 8, to which the volunteer is assigned; and

f) A signed statement that the loyalty oath or affirmation was taken or subscribed before an officer authorized to administer oaths. As approved by the Butte County Disaster Council on June 26, 2017. See Attachment F.

8. Classifications and General Duties

The various classifications of Disaster Service Worker Volunteers and the general duties of the members of each classification shall be limited to those described below. It is the responsibility of the accredited Disaster Council (or designated agency or authority) to determine the appropriate level of background check, if any, for each classification.

a) **Animal Rescue, Care and Shelter.** Veterinarians, veterinary support staff and animal handlers/specialists providing skills in the rescue, clinical treatment, euthanasia, disposal and transportation of all animals, including but not limited to companion animals, livestock, avian, fish, equine, exhibition animals, zoo animals, laboratory and research animals and wildlife; assisting in the procurement of shelters, equipment and supplies; documenting arrival, sheltering, treatment and discharge or placement of animals.

b) **Communications.** Install, operate and maintain various communications systems and perform related service, to assist officials and individuals in the protection of life and property.

c) **Community Emergency Response Team Member.** Under the direction of emergency personnel or a designated team leader, assist emergency units within their block, neighborhood, or other area assignment; survey area conditions; disseminate information; secure data desirable for emergency preparedness planning; report incidents; and generally assist officials and individuals in the protection of life and property.

d) **Emergency Operations Center (EOC)/Incident Command (IC).** Under the direction and supervision of the EOC/IC, assist at the city, county, region, state or departmental level of government in the coordination of overall response and support to an incident including performing in one or more of the Standardized Emergency Management System functions.

e) **Human Services.** Assist in providing food, clothing, bedding, shelter and rehabilitation aid; register evacuees to promote reuniting families and to support the needs of special populations; compile authoritative lists of deceased and missing persons; and other phases of emergency human services, such as maintaining morale and administering to the mental health, religious or spiritual needs of persons suffering from the effects of the disaster.

f) **Fire.** As auxiliary fire fighters or auxiliary wildland fire fighters, assist regular fire fighting forces or fire protection agencies to fight fire, rescue persons, and save property; control forest or wildland fires or fire hazards; instruct residents in fire prevention and property defense methods, methods of detecting fire, and precautions to be observed in reducing fire hazards.

    1) For purposes of these regulations only, the ratios between auxiliary fire fighters, volunteer fire fighters, and paid fire fighters shall be one auxiliary for one volunteer and three volunteers for one paid fire fighter. The basis for applying these ratios is that the staffing of an engine company, truck company, or a squad shall not exceed six paid fire fighters, and a salvage and rescue company shall not exceed two paid fire fighters. A fire department that has no volunteer fire fighters is limited to three auxiliary fire fighters for each paid fire fighter in the companies and squads, staffed as above. These staffing standards are based on the number of first line (not reserve) apparatus operated by the fire department

    2) When auxiliary fire fighters are registered with other than an established fire service organization; for example, auxiliary fire fighters in a county or city emergency management services organization, a total number of eligible auxiliary fire fighters shall be computed for that city or unincorporated area. The emergency management services organization is entitled to register auxiliary fire fighters not otherwise registered with other established fire service organizations, and to a number not to exceed the allowable total as indicated in Section 8 (f) (1) above

g) **Laborer.** Under the direction and supervision of the responding agency, performs general labor services and supports emergency operations.

h) **Law Enforcement.** As Auxiliaries, assist law enforcement officers and agencies to protect life and property; maintain law and order; perform traffic control duties; guard

buildings, bridges, factories, and other facilities; isolate and report unexploded ordinance.

i) **Logistics.** Under the direction of the emergency organization, assist in procurement, warehousing, and release of supplies, equipment materials, or other resources. Assist in mobilization and utilization of public and private transportation resources required for the movement of persons, materials, and equipment.

j) **Medical and Environmental Health.** Staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations; maintain or restore environmental sanitation; assist in preserving the safety of food, milk and water and preventing the spread of disease; perform laboratory analysis to detect the presence and minimize the effects of nuclear, chemical, biological, radiological or other hazardous agents.

k) **Safety Assessment Program Evaluator.** Survey, evaluate and assess damaged facilities for continued occupancy or use; assist in safety evaluations of facilities for utilities, transportation, and other vital community services; and provide recommendations regarding shoring or stabilization of damaged or unsafe buildings or structures.

l) **Search and Rescue (SAR).** Under the direction of the appropriate authority, perform search and rescue operations in one or more of several areas including, but not limited to: search and rescue; SAR conducted evidence searches; urban search and rescue; or mine and confined space rescue.

m) **Utilities.** Assist utility personnel in the repair and restoration of public utilities damaged by disaster.

9. Recordkeeping

For Disaster Service Worker Volunteers in the Sheriff's Comm Reserve and/or Search and Rescue, the oath or affirmation shall be filed in the Butte County Sheriff's Office.

For Disaster Service Worker Volunteers in the North Valley Animal Disaster Group, the oath or affirmation shall be filed in the Butte County Animal Control Office.

For Disaster Service Worker Volunteers that are not in the Sheriff's Comm Reserve, Search and Rescue or the North Valley Animal Disaster Group, the oath or affirmation shall be filed in the Butte County Office of Emergency Management.

These records shall be available for inspection by any officer or employee of the State Compensation Insurance Fund (SCIF) or of the California Governor's Office of Emergency Services.

10. Release of Volunteers from Service

DSW Volunteers who do not adhere to the rules, policies and regulations of Butte County, fail to perform their assignments satisfactorily, or are participating in activities that are no longer required are

subject to dismissal. A volunteer may be dismissed at any time. Butte County reserves the right to request that a volunteer leave immediately. No prior notification is necessary to release a volunteer of their services. If a volunteer's supervisor or other county official believes that a volunteer's behavior warrants immediate release, they have that right.

11. <u>Workers' Compensation Claims</u>

Injuries incurred by volunteers (as defined in Section 3 of this policy) are covered under the State of California Workers' Compensation program. If a DSW Volunteer is injured as a result of an authorized deployment or preapproved training, please follow procedures below:

1. Provide **SCIF e3301**, *Workers' Compensation Claim Form (DWC-1)* to injured DSW Volunteer within 24 hours[1] of knowledge of injury.
    a. DSW Volunteer completes 1-8 (top section) and returns it to immediate supervisor or registering agency within three days (72 hours) of receiving it.
    b. Immediate supervisor provides copy to DSW Volunteer and then completes 9-18 (bottom section). Leave line 15 blank.
    c. Completed form must be submitted to SCIF and Cal OES within 1 working day after receipt from DSW Volunteer. DSW Volunteer shall also be provided a copy of the completed form.

2. Complete **SCIF e3267**, *Employer's Report of Occupational Injury*, within 5 days of knowledge of injury. **OR**

Complete **SCIF e3267** over the phone with a Claims Reporting Representative. This expedites the claim initiation, especially for those employers without access to the paper form.

24 – Hour Claims Reporting Center (888) 222-3211

DSW Volunteer <u>DOES NOT</u> complete this form or receive a copy.

3. A written narrative account of the incident that may include witness statements.

4. A copy of the claimant's current disaster service worker volunteer registration form indicating the loyalty oath or affirmation was administered.

5. If injury due to a training activity, the claim shall also include:

[1] SCIF Brochure #13761, *New Disaster Service Worker's Guide to Workers' Compensation*, may be given to an injured DSW volunteer at the same time. Brochures may be obtained from your local SCIF office or from the Governor's Office of Emergency Services.

a. A copy of a training document verifying the disaster service worker volunteer's participation, and
b. A copy of the written pre-authorization of the training activity by the accredited disaster council or its designee.

6. Submit documents within time lines. DO NOT wait until you have all documents before submitting.

7. Keep copies of all documents in employer's file for injured DSW volunteer.

INSTRUCTIONS for SUPERVISING AGENCY

CLAIM ASSEMBLY AND DISTRIBUTION

DOCUMENT	STATE FUND	CAL OES	INJURED DSW VOLUNTEER	COMMENTS
State Fund Form e3267	Fax Copy & Mail Original	Fax or Scan Copy	*DO NOT PROVIDE COPY!*	State Fund Fax: 707-646-0173
State Fund Form e3301			Provide copy of: ① *Temporary Receipt* - *volunteer's proof of filing* ② Completed & signed Form - after bottom section completed	
DSW Registration & Oath	Fax Copy		DO NOT PROVIDE COPY!	Cal OES Fax: 916-845-8736
Incident Report				
*Training Pre-Authorization**				**Required for training injuries*
*Training Verification**				

NOTE: Supervising Agency (and Registering Agency) retain copy of entire claim submission. 11/2015

Contacts

Don Glueckert, DSW Volunteer Program Lead
California Emergency Management Agency
3650 Schriever Avenue
Mather, CA 95655
anita.chant@caloes.ca.gov
916-845-8763 (desk)
916-845-8736 (fax)
OR
Kathryn Chin, DSW Volunteer Program
kathryn.chin@caloes.ca.gov
916-845-8787 (desk)

Angie Trujillo
State Compensation Insurance Fund
Specialized Claims Operations
PO Box 65005
Fresno, CA 93650-5005
951-697-6341 (desk)
707-646-0173 (fax)
sllabowitz@scif.com

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACION AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt**" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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

Empleado: Complete la sección ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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

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 dia habil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ **Employer copy**/*Copia del Empleador* ☐ **Employee copy**/*Copia del Empleado* ☐ **Claims Administrator**/*Administrador de Reclamos* ☐ **Temporary Receipt**/*Recibo del Empleado*

RESET FORM

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE COMPENSATION INSURANCE FUND, CLAIMS MANAGEMENT SERVICE

24-Hour Claims Reporting Center
Telephone (888) 222-3211 Fax (800) 371-5905

ALSO SEND ONE COPY TO: CALIFORNIA EMERGENCY MANAGEMENT AGENCY - ATTENTION ANITA CHANT
3650 SCHRIEVER AVENUE, MATHER, CA 95655
BOTH SIDES OF THIS FORM MUST BE COMPLETED
(Claims Management Service is a division of State Compensation Insurance Fund)

OSHA Case No.

DR

☐ Fatality

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.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

COUNCIL

1. LOCAL ACCREDITED DISASTER COUNCIL
1a. Policy Number: **DIS REL**
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: **CALIFORNIA EMERGENCY MANAGEMENT AGENCY**
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☒ OTHER GOVERNMENT - SPECIFY: **DISASTER COUNCIL**

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED (mm/dd/yy) CLAIM FORM
19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.
19a. BODY PART AFFECTED
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)
20a. ZIP
20b. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)
27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
29. Employee treated in Emergency Room? ☐ YES ☐ NO

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(9)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

DISASTER WORKER

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City, Zip)
33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal ☐ disabled ☐ retired ☐ laid-off ☐ unemployed ☐ on strike ☐ other
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO
40. NAME AND ADDRESS OF PRESENT EMPLOYER

Completed By (type or print)
Signature & Title

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim: and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

e3267 (REV. 8-10)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

41. OCCUPATION (REGULAR JOB TITLE, NOT SPECIFIC ACTIVITY AT TIME OF INJURY)

42. WAS WORKER REGISTERED WITH A LOCAL ACCREDITED DISASTER COUNCIL? IF SO, WHICH _____

43. DID INJURY ARISE OUT OF ACTIVITIES AS A DISASTER SERVICE WORKER? _____