

SAN DIEGO UNIFIED SCHOOL DISTRICT

Date: August 24, 2016

To: All School Principals, Child Development Center Administrators, Division and Department Heads

Subject: MANDATORY POSTING REQUIREMENTS / SUPERVISOR'S REPORT OF INJURY/ILLNESS – FORM 78

Department and/or Persons Concerned: School Principals, Child Development Center Administrators, Division and Department Heads, Supervisors, Managers and Secretaries

Due Date: Immediately

Action Requested: Print and post new revised attached poster
1) *Occupational Medical Facilities* Print and keep for future use
2) *Supervisor's Report of Injury/Illness – Form 78*

Brief Explanation:

The Occupational Medical Facilities list has been updated. State law requires that California employers conspicuously display the mandatory posters at site central locations frequented by staff and where their employees can read them. Please replace the old version with the updated version *immediately*. Failure to comply may result in state-imposed monetary penalties to the site!

The Supervisor's Report of Injury/Illness – Form 78 – has also been updated. Please use this new version going forward and discard any older versions.

1. Occupational Medical Facilities – (*Revised July 2016 – 1 pg.*)
2. Supervisor's Report of Injury/Illness – Form 78 (*Revised July 2016 – 1pg.*)

If you have any questions please call (858) 627-7345.

Ashley K. Fenton
Manager, Insurance & Risk Services
Risk Management

APPROVED:



Andra Donovan
General Counsel
Legal Services Division

AKF:er

Attachments (2)

OCCUPATIONAL MEDICAL FACILITIES

MANDATED POSTER BY THE STATE OF CALIFORNIA

In case of workplace injury, first notify your supervisor

Call 911 if the injury or illness is an emergency

San Diego Unified School District has arranged for medical care to be provided at the specialized work related injuries/illness occupational medical facilities listed below. No appointment is necessary. Inform the medical facility that you are a SDUSD employee and request that they **send medical reports and billing to York Risk Services Group, Inc.**

In the event of a serious injury/illness of an employee: CALL CalOSHA at (619) 767-2280 within 8 hours of the accident.

Serious injury/illness is defined as any injury/illness occurring in a place of employment, or in connection with any employment, which requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation, or in which an employee suffers a loss of any member of body, or suffers any serious degree of permanent disfigurement. **Failure to report to CalOSHA may result in a fine of up to \$5,000 to the site.**

MISSION VALLEY/ HILLCREST

UCSD Medical Center Hillcrest

8:00 am - 4:30 pm
330 Lewis Street, Suite 100, SD 92103
(619) 471-9210

UCSD Medical Hospital Hillcrest

***After Hours Care**
200 W. Arbor Drive, SD 92103
(858) 657-7000

U.S. HealthWorks

7:00 am-7:00 pm
3930 Fourth Ave, Ste 200, SD 92103
(619) 297-9610

Kaiser On-the-Job

9:00 am - 4:00 pm
4647 Zion Ave., 1st Floor, SD 92120
(619) 528-5062

Kaiser Permanente Hospital

***After Hours Care**
4647 Zion Avenue, SD 92120
(619) 528-5700

Mission Valley Medical Center

8:00 am - 6:30 pm
5333 Mission Center Rd, Suite 100,
San Diego 92108
(619) 295-3355

CAMP PALOMAR

U.S. HealthWorks

7:00 am - 7:00 pm
860 W Valley Pkwy, Ste 150,
Escondido 92025
(760) 740-0707

CLAIREMONT/KEARNY MESA

U.S. HealthWorks (Open 24 hours)

5575 Ruffin Rd., Suite 100, SD 92123
(858) 277-2744

Sharp Rees-Stealy Genesee

8:00 am - 5:00 pm
2020 Genesee Avenue, SD 92123
(858) 616-8400

Sharp Emergency Room

7901 Frost St
San Diego CA 92123
(858) 939-3400

NORTH COUNTY

UCSD Medical Center UTC/La Jolla

8:00 am - 4:30 pm
8899 University Center Lane, Ste. 160,
San Diego 92122
(858) 657-1600

UCSD Medical Center Thornton Hospital

***After Hours Care**
9300 Campus Point Drive, La Jolla 92037
(858) 657-7612

U.S. HealthWorks

8:00 am - 5:00 pm
10350 Barnes Canyon Rd, Ste 200, SD 92121
(858) 455-0200
7590 Miramar Road, Suite C, SD 92126
(858) 549-4255

Sharp Rees-Stealy Sorrento Mesa

8:00 am - 5:00 pm
10243 Genetic Center Dr, SD 92121
(858) 526-6150
***After Hours Urgent Care (858) 526-6100**
5 p.m. - 8 p.m., Monday - Friday
8 a.m. - 8 p.m., Weekends/Holidays

Kaiser On-the-Job

9:00 am - 5:00pm
400 Craven Road, San Marcos 92078
(760) 510-5350

SOUTH BAY

U.S. HealthWorks

8:00 am - 6:00 pm
1111 Broadway, Suite 305,
Chula Vista 91911
(619) 425-8212
102 Mile of Cars, National City 91950
(619) 474-9211

Sharp Rees-Stealy Chula Vista

8:00 am - 5:00 pm
525 3rd Ave., Chula Vista 91910
(619) 585-4050
***After Hours Urgent Care (619) 585-4000**
Open 8 a.m. - 8 p.m. daily

Kaiser On-the-Job

9:00 am - 5:00 pm
4650 Palm Ave., Bldg B, 2nd Floor Area 24
San Diego 92154
(619) 662-5006

EAST COUNTY

U.S. HealthWorks

7:00 am - 6:00 pm
9745 Prospect Ave, Ste 100,
Santee 92071
(619) 448-4841

Sharp Rees-Stealy La Mesa

8:00 am - 5:00 pm
5525 Grossmont Center Dr, La Mesa 91942
(619) 644-6600
***After Hours Urgent Care (619) 644-6625**
Open 8 a.m. - 8 p.m. daily





- ❖ Complete all sections of the Supervisor's Report of Injury/Illness - Form 78 and fax to Risk Management at FAX (858) 627-7353 or scan and email to risk-management@sandi.net. Do not wait for the principal/department head's signature.
- ❖ Use additional pages as needed to provide all pertinent information regarding this employee's injury/illness.
- ❖ Contact Risk Management at (858) 627-7347 or risk-management@sandi.net to verify receipt of your report.
- ❖ Print and fax or scan/email a copy Supervisor's Report of Injury/Illness with Principal/Department Head's signature to Risk Management.

IMPORTANT: The site is required to call CalOSHA at (619) 767-2280 within 8 hours of the injury in the event of a serious injury or illness defined as requiring inpatient hospitalization for other than medical observation, or in which an employee suffers a loss of any member of body, or suffers any serious degree of permanent disfigurement. Failure to do so may result in a fine of up to \$5,000 to the site.

Employee Information							
Employee's First & Last Name		Position Title		School/Department	Location #	Work Phone #	Ext
Employee's Mailing Address (not SDUSD)			City	Zip Code	SDUSD Employee ID #		Home Phone #
Scheduled Days at Site <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun Total Hours Worked Per Week _____			Start Time <input type="checkbox"/> am <input type="checkbox"/> pm		End Time <input type="checkbox"/> am <input type="checkbox"/> pm		Non-Employee <input type="checkbox"/> Volunteer (Registered) <input type="checkbox"/> Student Paid by SDUSD
Injury/Illness Information							
Date of Injury/Onset of Illness		Time Injury/Illness Occurred <input type="checkbox"/> am <input type="checkbox"/> pm		Witnesses <input type="checkbox"/> No <input type="checkbox"/> Yes, full name(s)			
What part of body is affected? <i>(Example: index finger, left ankle, upper back)</i>				What is the specific injury/illness? <i>(Example: cut, sprain, strain)</i>			
Describe How Injury/Illness Occurred. Describe sequence of events. Specify object or exposure which directly produced the injury/illness. <i>(Example: Employee was walking from the classroom to the administration office when she tripped over uneven pavement and fell on both knees)</i>							
Where did the injury/illness occur?							
School/Department:		Address:			City:		Zip Code:
Was Employee acting within the normal course of duties? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, explain)							
Any equipment, chemical, materials, etc. used at time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain)							
Are physical repairs necessary to site? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, explain)							
Was employee following safety procedure(s) when injury occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, explain)							
Has corrective action been taken to prevent a recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain)							
Medical Treatment (Select One Below) - Employee receiving medical treatment may not return to work without a medical release.							
<input type="checkbox"/> NO Medical Treatment Sought							
<input type="checkbox"/> NO Medical Treatment Sought. Employee was seen by School Nurse. _____							
<input type="checkbox"/> YES, Medical Treatment Sought. Provide Medical Facility Name and Address _____							
<input type="checkbox"/> YES, Medical Treatment Sought. Employee has a Pre-Designation of Personal Physician Form on file with the Risk Management Department.							
Medical Facility & Physician's Full Name: _____							
Address:(Street, City, Zip) _____ Phone: _____							
Completed By: (Supervisor, not injured employee, to report work-related injury/illness)							
Print Name			Title			Work Phone #	Ext #
Date of Supervisor's Knowledge/Notice of Injury/Illness			Signature			Date Signed	
Principal/Department Head							
Print Name			Title		Signature		Date Signed