PROVIDENCE
Health & Services
California

CAREGIVER HEALTH SERVICES

VOLUNTEER PACKET CONTENTS

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PROVIDENCE
Health & Services
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CAREGIVER HEALTH SERVICES

ONBOARDING REQUIREMENTS FOR VOLUNTEERS

Providence Health & Services requires all Caregivers to be screened for Tuberculosis.
This screening is done by a one-time blood test, called Quantiferon Gold.

- Please fill out all attached forms (prior to going Caregiver Health Services Office)
- If you have had a previous positive TB skin test, please speak with the Nurse and provide proof.

  - Quantiferon Gold Blood testing is done at the lab. You will be directed where to go.

***Please note:** Any test results (other than negative) will require follow up in Caregiver Health, as well as a possible Chest X-Ray and a Medical Clearance from your own primary care physician. **You may not begin volunteering until all requirements have been completed.**

Each year, All Caregivers are required to complete the annual TB screening requirements. This is done during your birth month. Your cooperation in complying with the requirements will enable PH&S to comply with the standards that OSHA (Occupational Safety and Health Administration) has set for all hospitals. Please contact Caregiver Health Services if you have any questions regarding this requirement.

Other requirements:

Immunization Records. Please provide documentation of all immunizations.

Flu Shot: Can be provided in CHS, (during flu season) or you must provide proof of vaccination or declination.

***Dept. of Public Health Mandate:** Any Caregiver who does not receive a flu shot will be required to wear a simple mask at all times (except in cafeteria), while working within the hospital, during flu season (October thru March).

Parental Consent for the blood test and/or flu shot must be signed for all volunteers that are younger than 18 years of age.

You may contact any Caregiver Health Services 7:30a-3:30p (Offices close at 4:00p)

Providence Little Company of Mary - Torrance **EMPLOYEE HEALTH SERVICES** 4101 Torrance Blvd. Torrance Ca 90503 Tel No: 310.303.6720	**Providence Tarzana Med. Ctr.** **EMPLOYEE HEALTH SERVICES** **M-W-F ONLY** 18321 Clark St. Tarzana, CA 91356 Tel No : 818.708.5043	**Providence St. Joseph's** **EMPLOYEE HEALTH SERVICES** 501 So. Buena Vista St. Burbank, CA 91505 Tel No: 818.847.3739
Providence Little Company of Mary-San Pedro **EMPLOYEE HEALTH SERVICES** **M-W-F ONLY** 1300 W. Seventh Street San Pedro, CA 90732 Tel No: 310.514.5209	**Saint John's Health Center** **EMPLOYEE HEALTH SERVICES** 2121 Santa Monica Blvd. Santa Monica, CA 90404 Tel No: 310.829.8746	**Holy Cross Medical Center** **EMPLOYEE HEALTH SERVICES** 15031 Rinaldi Street Mission Hills, CA 91345-1208 Tel No: 818.496.4760

☐	PHCMC
☐	PLCMMC-T
☐	PLCMCC-SP
☐	PSJMC-BUR
☐	PTMC
☐	PSJHC-SM

CAREGIVER HEALTH SERVICES

VOLUNTEER ONBOARDING DEMOGRAPHICS

PLEASE PRINT LEGIBLY

NAME: _____

ADDRESS: _____

_____

EMAIL: _____@_____
FOR YOUR CONVENIENCE ONLY. NOT REQUIRED

PHONE (_____) _____-_____

SSN: _____-_____-_____

DOB: _____/_____/_____

PROVIDENCE Health & Services

Volunteer Tuberculosis Screening Questionnaire

Name:_____ **Date of Birth:** _____
Last First Middle

Do you currently have symptoms of:		**If yes, please explain:**
Productive cough for more than three weeks?	❑ Yes ❑ No	
Fever associated with cough for more than one week?	❑ Yes ❑ No	
Blood present in sputum?	❑ Yes ❑ No	
Night sweats?	❑ Yes ❑ No	
Unusual fatigue for more than two weeks?	❑ Yes ❑ No	
Loss of appetite for more than two weeks?	❑ Yes ❑ No	
Unexplained weight loss (of five pounds or more)?	❑ Yes ❑ No	
Current health status		**If yes, please explain:**
Do you have an acute viral infection or febrile illness?	❑ Yes ❑ No	
Have you had a live-virus vaccine in the past six weeks?	❑ Yes ❑ No	
Are you currently taking steroids (cortisone)?	❑ Yes ❑ No	
Are you currently undergoing radiation therapy, chemotherapy or immunosuppressive therapy?	❑ Yes ❑ No	
History		**If yes, please explain:**
Are you foreign-born?	❑ Yes ❑ No	Country:
Have you been out of the country within the last six months?	❑ Yes ❑ No	Country:
Have you ever had a TB skin or blood test?	❑ Yes ❑ No	
Have you ever had a positive reaction?	❑ Yes ❑ No	Date:
Have you had a recent chest x-ray?	❑ Yes ❑ No	Date:
Is there anyone in your family with TB?	❑ Yes ❑ No	Relationship:
Have you ever had close contact with active TB (including health care exposure)?	❑ Yes ❑ No	
Have you ever been treated with TB medications?	❑ Yes ❑ No	
Have you received the BCG vaccination?	❑ Yes ❑ No	
Do you have diabetes?	❑ Yes ❑ No	

To my knowledge, the above information is correct. I consent for a TST (TB skin test) or IGRA blood test.

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease, if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

Caregiver Signature:_____ **Date:** _____

EHS Representative: _____ **Date:** _____

PROVIDENCE
Health & Services
California

☐	PHCMC
☐	PLCMMC-T
☐	PLCMCC-SP
☐	PSJHC
☐	PSJMC
☐	PTMC

CAREGIVER HEALTH SERVICES

PARENTAL CONSENT FOR THE QUANTIFERON TB GOLD BLOOD TEST

The Quantiferon TB Gold test is a blood test that has a higher sensitivity and specificity to latent Mycobacterium Tuberculosis infection than a purified protein derivative (PPD) skin test and is required of all employees and volunteers at all Providence Health & Services acute and post acute facilities. The blood test requires blood to be drawn from a vein and no return visit is necessary.

A chest x-ray will be performed at no cost if a there is a positive result to determine if active disease is present, and the volunteer will be sent to their primary physician for evaluation and clearance.

Only when the testing process is complete will clearance be issued. Further information on Tuberculosis is available from Caregiver Health Services.

****

Consent

I am the parent/legal guardian of _____ (name of minor)
I have read and understand the above and I consent to the Quantiferon TB Gold lab test and, if needed, a chest x-ray.

I consent to pre-placement TB testing as well as annual TB surveillance, if applicable.

Please print name: _____ Date: _____

Signature: _____

Please provide best number to reach you with results: _____

All employees and volunteers are required to comply with annual TB surveillance.
This consent will remain on file for as long as this person is an active volunteer and will serve as consent for all TB Surveillance.
If he/she becomes inactive, a new consent will need to be obtained upon return to active status.

PROVIDENCE
Health & Services
California

Caregiver Health Services

VOLUNTEER ONBOARDING LAB REQUISITION

☐ PLCMMC-T (*EMPLCT*) ☐ PLCMMC-SP (*EMPLCS*) ☐PTMC (*EMPPTZ*)

☐PSJMC (*EMPPSJ*) ☐PSJHC(*EMPCJN*) ☐ PHCMC (*EMPPHC*)

Name: _____ **Birthdate:** _____

Date Ordered: _____

_____
EHN SIGNATURE

Date Drawn: _____ **Drawn By:** _____

Ordered By: Dr. James Deutsch/EH Med Director
310-618-9200
2382 Crenshaw Blvd Ste 5 Torrance, CA 90501

Required for all volunteers:

- ☐ Quantiferon Gold

Please do the following, only if checked:

- ☐ Rubeola Antibody, IGG
- ☐ Rubella Antibody
- ☐ Mumps Titer
- ☐ Hepatitis B surface antibody
- ☐ Varicella Antibody, IGG

PROVIDENCE
Health & Services
California

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

I acknowledge that I have received the following information:
New Hire Notice-Injuries Caused By Work

_____
Caregiver Name (please print)

_____ _____
Caregiver Signature Today's Date

I understand that my predesignation is not valid until the completed certification from my physician has been submitted to Employee Health Services.

ACUSE de RECIBO de INFORMACIÓN

Reconozco que he recibido la siguiente información:
Notificación de nueva contratación – Lesiones Ocasionadas En El Trabajo

_____
Nombre del Empleado (escriba con letra de molde)

_____ _____
Firma del Empleado Fecha Actual

Yo entiendo que autorización de predesignación no es valida hasta que haya sido certificada por mi medico y entregada al departamento de Employee Health Services.

PROVIDENCE Health & Services

Employee Health Services

Tetanus, Diphtheria, acellular Pertussis (Tdap) Combined

Caregiver Name:	ID Number:
Date:	Department/Position:

The Advisory Committee on Immunization Practices (Centers for Disease Control) recommends that all health care personnel regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose. Pertussis is highly contagious and vaccine is highly recommended and is offered free from Employee Health Services to all Providence caregivers. We would like to encourage you to review the information provided by the Employee Health nurse and consider getting the vaccine.

Acceptance/Declination Statement

I have read the information about the Tdap vaccine. I have had the opportunity to ask questions or consult with my physician, if desired. Any questions were answered to my satisfaction. I understand the benefits and risks of the vaccine. I understand the Tdap vaccine is available to me at no cost upon request through Employee Health Services.

- ☐ REQUEST that the combined Tdap vaccine be given to me.
- ☐ PREVIOUS IMMUNIZATION: I have received the combined Tdap vaccine as an adult booster since 2006 and I have provided the supporting documentation.
- ☐ I DECLINE: I understand that by declining the vaccine, I am at risk of being exposed and/or contracting Pertussis. If I am exposed to Pertussis, I will not be allowed to work during the incubation period or during the resulting illness. In the future, if I want to be vaccinated with Tdap, I can receive the vaccination from Providence Employee Health Services at no cost to me.

Health History Questions	Yes	No	If yes, describe briefly:
Have you ever had a life threatening allergic or neurologic reaction (coma or seizure) after a dose of DPT, Dtap, DT, or TD?			
Do you have epilepsy or another nervous system problem, such as Guillain Barre' Syndrome (GBS)?			
Have you ever had severe swelling or pain after a DPT, Dtap, DT, TD or Tdap vaccine? (A 'severe' problem means unable to perform usual activities and/or required medical attention)			
Are you pregnant?			
Are you moderately or severely ill today?			
Do you have a known allergy or sensitivity to latex?			

Caregiver Signature:	**Date:**

EHS USE ONLY

Tdap Lot :	**VIS Version & Date:**	
Expiration Date:	**Route: IM Deltoid**	**Deltoid: Left Right** (circle one)
Vaccine Administrator Signature:		**Date:**

PROVIDENCE Health & Services

Varicella (Chickenpox) Vaccine Accept/Decline

Employee Health Services rev 8.15.2016

Caregiver Name:	ID Number:
DOB:	Department/Position:

I voluntarily authorize Providence Employee Health Services to administer the varicella vaccine. The purpose of receiving the varicella vaccine is to promote immunity to varicella. The varicella vaccine may be given at the same time as other vaccines.

There is a strong likelihood that the vaccine will be successful in preventing the varicella virus. However, a small percentage of recipients do not receive the desired results. There is a small possibility that I may develop symptoms associated with the varicella virus. I also understand that the vaccine will not prevent the disease if I am already infected with varicella.

Health History Questions	Yes	No	If yes, describe briefly:
Do you have a fever, or are you ill today?			
Do you have a serious medical condition(s) and are under the care of a provider?			
Have you ever had a reaction to any vaccination?			
Women of child bearing age: Are you pregnant or planning to become pregnant in the next 4-6 weeks?			
Do you have a known allergy to the antibiotic neomycin?			
Do you have cancer, leukemia, HIV/AIDS or any other immune system diseases? Are you taking any *drugs or treatments* (ex. Prednisone, Humira) that affect the immune system for 2-weeks or longer?			
Are you in close contact to family members or others who have immune system diseases? (If yes, require a medical clearance from provider)			
Have you had a transfusion or have you been given blood products recently?			
Have you received any other vaccinations or tuberculin skin testing in the last 4 weeks?			

I have read or had explained to me the information about the varicella vaccine. I have had the opportunity to ask questions, and they were answered to my satisfaction. I believe that I understand the benefits and risks of the above vaccine(s) and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. ***I am currently not pregnant and I will not become pregnant during the 4-weeks following the vaccine.***

Caregiver Signature:	**Date:**
I acknowledge that I have reviewed the above information with the caregiver. Nurse initial_____	**Date:**

Date Varicella given mo/day/yr	Time Given	Route	Site Given Upper Posterior Arm	Vaccine	Diluent	Dose	Mfr.	VIS Date	Clinician Signature
		SubQ	LT RT	Lot# Exp. Date	Lot# Exp. Date	0.5ml			

I DECLINE: I understand that by declining the vaccine, I continue to be at risk for varicella which is a serious disease. If I am exposed to varicella, I will not be allowed to work during the incubation period or during the resulting illness. In the future, if I want to be vaccinated for varicella, I can receive the vaccination from Providence Employee Health Services at no cost to me.

Caregiver Signature:_____ **Date:**_____

PROVIDENCE Health & Services

Employee Health Services

Measles, Mumps, Rubella (MMR) Vaccine Accept/Decline

rev 8-15-2016

Caregiver Name:	ID Number:
DOB:	Department/Position:

I voluntarily authorize Providence Employee Health Services to administer the measles, mumps, rubella (MMR) vaccine. The purpose of receiving the MMR vaccine is to promote immunity to MMR diseases. The MMR vaccine may be given at the same time as other vaccines.

There is a strong likelihood that the vaccine will be successful in preventing the MMR diseases. However, a small percentage of recipients do not receive the desired results. There is a small possibility that I may develop symptoms associated with the MMR viruses. I also understand that the vaccine will not prevent the disease if I am already infected with measles, mumps, or rubella.

Health History Questions	Yes	No	If yes, describe briefly:
Do you have a fever, or are you ill today?			
Do you have a serious medical condition(s) and are under the care of a provider?			
Have you ever had a reaction to any vaccination?			
Women of child bearing age: Are you pregnant or planning to become pregnant in the next 4-6 weeks?			
Do you have a known allergy to the antibiotic neomycin?			
Do you have cancer, leukemia, HIV/AIDS or any other immune system diseases? Are you taking any drugs or treatments (ex. Prednisone, Humira) that affect the immune system for 2-weeks or longer?			
Are you in close contact to family members or others who have immune system diseases? (If yes, require a medical clearance from provider)			
Have you had a transfusion or have you been given blood products recently?			
Have you received any other vaccinations or tuberculin skin testing in the last 4 weeks?			

I have read or had explained to me the information about the MMR vaccine. I have had the opportunity to ask questions, and they were answered to my satisfaction. I believe that I understand the benefits and risks of the above vaccine(s) and I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. **I am currently not pregnant and I will not become pregnant during the 4-weeks following the vaccine.**

Caregiver Signature:	**Date:**
I acknowledge that I have reviewed the above information with the caregiver. Nurse initial_____	**Date:**

Date MMR given mo/day/yr	Time Given	Route	Site Given Posterior Arm	Vaccine	Diluent	Dose	Mfr.	VIS Date	Clinician Signature
		SubQ	LT RT	Lot#	Lot#	0.5ml			
				Exp. Date	Exp. Date				

I DECLINE: I understand that by declining the vaccine, I continue to be at risk for measles, mumps, or rubella, which are serious diseases. If I am exposed to one of the diseases, I will not be allowed to work during the incubation period or during the resulting illness. In the future, if I want to be vaccinated for MMR, I can receive the vaccination from Providence Employee Health Services at no cost to me.

Caregiver Signature: _____ **Date:** _____

VACCINE INFORMATION STATEMENT

Tdap Vaccine

What You Need to Know

(Tetanus, Diphtheria and Pertussis)

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tetanus, diphtheria and **pertussis** are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis..

TETANUS (Lockjaw) is rare in the United States today. It causes painful muscle tightening and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so you can't open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 10 people who are infected even after receiving the best medical care.

DIPHTHERIA is also rare in the United States today. It can cause a thick coating to form in the back of the throat.

- It can lead to breathing problems, heart failure, paralysis, and death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep.

- It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death.

These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through secretions from coughing or sneezing. Tetanus enters the body through cuts, scratches, or wounds.

Before vaccines, as many as 200,000 cases of diphtheria, 200,000 cases of pertussis, and hundreds of cases of tetanus, were reported in the United States each year. Since vaccination began, reports of cases for tetanus and diphtheria have dropped by about 99% and for pertussis by about 80%.

2 Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did *not* get Tdap at that age should get it as soon as possible.

Tdap is especially important for healthcare professionals and anyone having close contact with a baby younger than 12 months.

Pregnant women should get a dose of Tdap during **every pregnancy**, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Another vaccine, called Td, protects against tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have never gotten Tdap before. Tdap may also be given after a severe cut or burn to prevent tetanus infection.

Your doctor or the person giving you the vaccine can give you more information.

Tdap may safely be given at the same time as other vaccines.

3 Some people should not get this vaccine

- A person who has ever had a life-threatening allergic reaction after a previous dose of any diphtheria, tetanus or pertussis containing vaccine, OR has a severe allergy to any part of this vaccine, should not get Tdap vaccine. Tell the person giving the vaccine about any severe allergies.
- Anyone who had coma or long repeated seizures within 7 days after a childhood dose of DTP or DTaP, or a previous dose of Tdap, should not get Tdap, unless a cause other than the vaccine was found. They can still get Td.
- Talk to your doctor if you:
  - have seizures or another nervous system problem,
  - had severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis,
  - ever had a conditioned called Guillain-Barré Syndrome (GBS),
  - aren't feeling well on the day the shot is scheduled.

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Centers for Disease Control and Prevention

4 Risks

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own. Serious reactions are also possible but are rare.

Most people who get Tdap vaccine do not have any problems with it.

Mild problems following Tdap
(Did not interfere with activities)

- Pain where the shot was given (about 3 in 4 adolescents or 2 in 3 adults)
- Redness or swelling where the shot was given (about 1 person in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents or 1 in 100 adults)
- Headache (about 3 or 4 people in 10)
- Tiredness (about 1 person in 3 or 4)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents or 1 in 10 adults)
- Chills, sore joints (about 1 person in 10)
- Body aches (about 1 person in 3 or 4)
- Rash, swollen glands (uncommon)

Moderate problems following Tdap
(Interfered with activities, but did not require medical attention)

- Pain where the shot was given (up to 1 in 5 or 6)
- Redness or swelling where the shot was given (up to about 1 in 16 adolescents or 1 in 12 adults)
- Fever over 102°F (about 1 in 100 adolescents or 1 in 250 adults)
- Headache (about 1 in 7 adolescents or 1 in 10 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 or 3 people in 100)
- Swelling of the entire arm where the shot was given (up to about 1 in 500).

Severe problems following Tdap
(Unable to perform usual activities; required medical attention)

- Swelling, severe pain, bleeding and redness in the arm where the shot was given (rare).

Problems that could happen after any vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at fewer than 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.
- Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your doctor. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

VACCINE INFORMATION STATEMENT

Varicella (Chickenpox) Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Varicella (also called chickenpox) is a very contagious viral disease. It is caused by the varicella zoster virus. Chickenpox is usually mild, but it can be serious in infants under 12 months of age, adolescents, adults, pregnant women, and people with weakened immune systems.

Chickenpox causes an itchy rash that usually lasts about a week. It can also cause:
- fever
- tiredness
- loss of appetite
- headache

More serious complications can include:
- skin infections
- infection of the lungs (pneumonia)
- inflammation of blood vessels
- swelling of the brain and/or spinal cord coverings (encephalitis or meningitis)
- blood stream, bone, or joint infections

Some people get so sick that they need to be hospitalized. It doesn't happen often, but people can die from chickenpox. Before varicella vaccine, almost everyone in the United States got chickenpox, an average of 4 million people each year.

Children who get chickenpox usually miss at least 5 or 6 days of school or childcare.

Some people who get chickenpox get a painful rash called shingles (also known as herpes zoster) years later.

Chickenpox can spread easily from an infected person to anyone who has not had chickenpox and has not gotten chickenpox vaccine.

2 Chickenpox vaccine

Children 12 months through 12 years of age should get 2 doses of chickenpox vaccine, usually:
- First dose: 12 through 15 months of age
- Second dose: 4 through 6 years of age

People 13 years of age or older who didn't get the vaccine when they were younger, and have never had chickenpox, should get 2 doses at least 28 days apart.

A person who previously received only one dose of chickenpox vaccine should receive a second dose to complete the series. The second dose should be given at least 3 months after the first dose for those younger than 13 years, and at least 28 days after the first dose for those 13 years of age or older.

There are no known risks to getting chickenpox vaccine at the same time as other vaccines.

There is a combination vaccine called MMRV that contains both chickenpox and MMR vaccines. MMRV is an option for some children 12 months through 12 years of age. There is a separate Vaccine Information Statement for MMRV. Your health care provider can give you more information.

3 Some people should not get this vaccine

Tell your vaccine provider if the person getting the vaccine:

- **Has any severe, life-threatening allergies.** A person who has ever had a life-threatening allergic reaction after a dose of chickenpox vaccine, or has a severe allergy to any part of this vaccine, may be advised not to be vaccinated. Ask your health care provider if you want information about vaccine components.
- **Is pregnant, or thinks she might be pregnant.** Pregnant women should wait to get chickenpox vaccine until after they are no longer pregnant. Women should avoid getting pregnant for at least 1 month after getting chickenpox vaccine.
- **Has a weakened immune system** due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy).
- **Has a parent, brother, or sister with a history of immune system problems.**
- **Is taking salicylates (such as aspirin).** People should avoid using salicylates for 6 weeks after getting varicella vaccine.
- **Has recently had a blood transfusion or received other blood products.** You might be advised to postpone chickenpox vaccination for 3 months or more.
- **Has tuberculosis.**

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Centers for Disease Control and Prevention

- **Has gotten any other vaccines in the past 4 weeks.** Live vaccines given too close together might not work as well.
- **Is not feeling well.** A mild illness, such as a cold, is usually not a reason to postpone a vaccination. Someone who is moderately or severely ill should probably wait. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Getting chickenpox vaccine is much safer than getting chickenpox disease. Most people who get chickenpox vaccine do not have any problems with it.

After chickenpox vaccination, a person might experience:

Minor events:

- Sore arm from the injection
- Fever
- Redness or rash at the injection site

If these events happen, they usually begin within 2 weeks after the shot. They occur less often after the second dose.

More serious events following chickenpox vaccination are rare. They can include:

- Seizure (jerking or staring) often associated with fever
- Infection of the lungs (pneumonia) or the brain and spinal cord coverings (meningitis)
- Rash all over the body

A person who develops a rash after chickenpox vaccination might be able to spread the varicella vaccine virus to an unprotected person. Even though this happens very rarely, anyone who gets a rash should stay away from people with weakened immune systems and unvaccinated infants until the rash goes away. Talk with your health care provider to learn more.

Other things that could happen after this vaccine:

- People sometimes faint after medical procedures, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your doctor if you feel dizzy or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions to a vaccine are estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your health care provider.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

VACCINE INFORMATION STATEMENT

MMR (Measles, Mumps, and Rubella) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Measles, mumps, and **rubella** are viral diseases that can have serious consequences. Before vaccines, these diseases were very common in the United States, especially among children. They are still common in many parts of the world.

Measles

- Measles virus causes symptoms that can include fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body.
- Measles can lead to ear infections, diarrhea, and infection of the lungs (pneumonia). Rarely, measles can cause brain damage or death.

Mumps

- Mumps virus causes fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears on one or both sides.
- Mumps can lead to deafness, swelling of the brain and/or spinal cord covering (encephalitis or meningitis), painful swelling of the testicles or ovaries, and, very rarely, death.

Rubella (also known as German Measles)

- Rubella virus causes fever, sore throat, rash, headache, and eye irritation.
- Rubella can cause arthritis in up to half of teenage and adult women.
- If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

These diseases can easily spread from person to person. Measles doesn't even require personal contact. You can get measles by entering a room that a person with measles left up to 2 hours before.

Vaccines and high rates of vaccination have made these diseases much less common in the United States.

2 MMR vaccine

Children should get 2 doses of MMR vaccine, usually:

- First dose: 12 through 15 months of age
- Second dose: 4 through 6 years of age

Infants who will be traveling outside the United States when they are between 6 and 11 months of age should get a dose of MMR vaccine before travel. This can provide temporary protection from measles infection, but will not give permanent immunity. The child should still get 2 doses at the recommended ages for long-lasting protection.

Adults might also need MMR vaccine. Many adults 18 years of age and older might be susceptible to measles, mumps, and rubella without knowing it.

A third dose of MMR might be recommended in certain mumps outbreak situations.

There are no known risks to getting MMR vaccine at the same time as other vaccines.

There is a combination vaccine called **MMRV** that contains both chickenpox and MMR vaccines. MMRV is an option for some children 12 months through 12 years of age. There is a separate Vaccine Information Statement for MMRV. Your health care provider can give you more information.

3 Some people should not get this vaccine

Tell your vaccine provider if the person getting the vaccine:

- **Has any severe, life-threatening allergies.** A person who has ever had a life-threatening allergic reaction after a dose of MMR vaccine, or has a severe allergy to any part of this vaccine, may be advised not to be vaccinated. Ask your health care provider if you want information about vaccine components.
- **Is pregnant, or thinks she might be pregnant.** Pregnant women should wait to get MMR vaccine until after they are no longer pregnant. Women should avoid getting pregnant for at least 1 month after getting MMR vaccine.
- **Has a weakened immune system** due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy).
- **Has a parent, brother, or sister with a history of immune system problems.**
- **Has ever had a condition that makes them bruise or bleed easily.**
- **Has recently had a blood transfusion or received other blood products.** You might be advised to postpone MMR vaccination for 3 months or more.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- **Has tuberculosis.**
- **Has gotten any other vaccines in the past 4 weeks.** Live vaccines given too close together might not work as well.
- **Is not feeling well.** A mild illness, such as a cold, is usually not a reason to postpone a vaccination. Someone who is moderately or severely ill should probably wait. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Getting MMR vaccine is much safer than getting measles, mumps, or rubella disease. Most people who get MMR vaccine do not have any problems with it.

After MMR vaccination, a person might experience:

Minor events:

- Sore arm from the injection
- Fever
- Redness or rash at the injection site
- Swelling of glands in the cheeks or neck

If these events happen, they usually begin within 2 weeks after the shot. They occur less often after the second dose.

Moderate events:

- Seizure (jerking or staring) often associated with fever
- Temporary pain and stiffness in the joints, mostly in teenage or adult women
- Temporary low platelet count, which can cause unusual bleeding or bruising
- Rash all over body

Severe events occur very rarely:

- Deafness
- Long-term seizures, coma, or lowered consciousness
- Brain damage

Other things that could happen after this vaccine:

- People sometimes faint after medical procedures, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions to a vaccine are estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

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What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your health care provider.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement

MMR Vaccine

Office use only

2/12/2018 | 42 U.S.C. § 300aa-26

PROVIDENCE
Health & Services
California

CAREGIVER HEALTH SERVICES

INJURY REPORTING INFORMATION FOR VOLUNTEERS

PLEASE REPORT ALL WORK RELATED INJURIES TO
CAREGIVER HEALTH SERVICES AND THE VOLUNTEER DIRECTOR
YOUR INJURY MUST BE REPORTED TELEPHONICALLY,
BY THE VOLUNTEER DIRECTOR
AND FOLLOW UP WITH CAREGIVER HEALTH SERVICES

IMPORTANT	**An ER visit is not necessary in order to document the occurrence of a work injury.** All injuries/illness/exposures must be immediately reported to Volunteer Director, Caregiver Health or the House Supervisor. All injuries should be directed to Caregiver Health during office hours listed below.
Caregiver Health Hours	**Monday-Friday 7:30 am – 4:00 pm** In the event that your local Caregiver Health Office is not open, you can still be taken care of at one of the other local ministries, either telephonically or in person. During our off hours, please contact the House Supervisor for any urgent needs

Providence Little Company of Mary – Torrance **EMPLOYEE HEALTH SERVICES** 4101 Torrance Blvd. Torrance Ca 90503 Tel No: 310-303-6720	**Providence Tarzana Medical Center** **EMPLOYEE HEALTH SERVICES** **M-W-F ONLY** 18321 Clark St. Tarzana, CA 91356 Tel No : 818-708-5043	**Providence St. Joseph** **EMPLOYEE HEALTH SERVICES** 501 S. Buena Vista Street Burbank, CA 91505-4809 Tel No : 818-847-3739
Little Company of Mary-San Pedro **EMPLOYEE HEALTH SERVICES** **M-W-F ONLY** 1300 W. Seventh Street San Pedro, CA 90732 Tel No: 310-514-5209	**Saint John's Health Center** **EMPLOYEE HEALTH SERVICES** 2121 Santa Monica Blvd. Santa Monica, CA 90404 Tel No: 310-829-8746	**Holy Cross Medical Center** **EMPLOYEE HEALTH SERVICES** 15031 Rinaldi Street Mission Hills, CA 91345-1208 Tel No: 818-496-4760

MUST REPORT TO VOLUNTEER DIRECTOR	**ALL INJURIES MUST BE REPORTED TO VOLUNTEER DIRECTOR OR DESIGNEE**

New Hire Notice -- Injuries Caused By Work

What does workers' compensation cover?

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures such as hurting your wrist from doing the same motion over and over). Generally, independent contractors, and volunteers who receive no compensation are not covered by workers' compensation benefits.

Benefits:

Workers' compensation benefits include: Medical care, temporary disability, permanent disability, supplemental job displacement voucher, and death benefits

Medical Care:

You are entitled to medical care that is reasonably required to cure or relieve you from the effects of your work-related injury. Medical care may include doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. Providers should never bill you directly for work-related injuries. There is a limit on some medical services. Your employer is required to provide you with a claim form within one business day of learning about your injury. It is extremely important that you complete the "Employee" section of the claim form as your employer is required to authorize medical care within one working day after you file the form. If additional care is necessary after the initial treatment, the claims administrator will authorize any care that is appropriate for your injury, including the referral to specialists.

Your Primary Treating Physician (PTP):

This is the doctor with overall responsibility for treating your injury or illness. The primary treating physician determines what type of treatment you need and when you may return to work. A multispecialty medical group of licensed doctors and osteopathy can be designated as personal physicians. If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work- related injury or illness by making a request to the claims administrator. Chiropractors may not continue as the primary treating physician after 24 visits. If specialists, diagnostics, etc. are needed in your case, this physician will be responsible for making the referrals. If you name your personal physician before your injury, you may see him or her for treatment in certain circumstances.

Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Special rules apply if your employer offers a Health Care Organization (HCO) or has a medical provider network. You should receive information from your employer if you are covered by an HCO or MPN. Contact your employer for more information.

Treatment by your personal physician:

You may be treated by your personal physician if you notify your employer prior to your injury. A personal physician includes a medical group of licensed doctors of medicine or osteopathy. Please have your physician complete the attached form and return to your employer. The following requirements must be met:

1. Your employer must offer group health coverage
2. Your personal physician must agree in advance to treat you for any work injuries or illnesses
3. Your physician must be your regular physician and surgeon.
4. Your physician has previously directed your medical treatment and retains your records, including your medical history.

What happens if your employer disputes your injury?

State law requires employers to authorize medical care within one working day of receiving a DWC 1 claim form. Your employer may be liable for as much as $10,000 in medical care until your claim is accepted or denied.

Medical Provider Networks:

Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If you have predesignated your personal physician prior to your work injury, then you may receive treatment from your predesignated doctor. If you have not predesignated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by the employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information see the MPN contact information below.

Medical Access Assistant for California MPNs:

The Medical Access Assistant, or MAA, has the primary duty of assisting employees with finding available medical provider network physicians and scheduling medical appointments. The MAA shall be available Monday through Saturday from 7:00 AM – 8:00 PM (Pacific standard time).

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The MAA will contact the physician during normal business hours to schedule your appointment. The MAA does not have authority to authorize treatment and maintains different duties than the claims examiner.

Sedgwick Medical Access Assistant:

Phone: **1-87-SEDGWICK** or **1-877-334-9425**

Current MPN toll free number: 800-625-6588

MPN Website: www.sedgwickproviders.com/campn2

- Select method of search: physician name, address search, or region search
- Input the state and zip code information
- Click "Find Provider"

Current MPN Address:

Sedgwick CMS
10690 White Rock Road Suite 100
Rancho Cordova, CA 95670
MPN Effective Date: 06/01/2017

What if my employer does not have a Medical Provider Network?

If your employer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness within 30 days of reporting your injury. You may use the attached Notice of Personal Chiropractor or Personal Acupuncturist form to notify your employer of this change.

Emergency Medical Care:

If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department.

First Aid:

If you need first aid treatment, contact your employer. If you have more than a simple first aid injury, you will need to ask your employer for a claim form.

Temporary Disability (TD) Benefits:

You may be entitled to payments if you lose wages while recovering. Your temporary disability rate is calculated by multiplying your average weekly wage by two thirds. The first 3 days of disability are not payable under California law unless there is hospitalization at the time of injury or the disability exceeds 14 days. If your physician returns you to work on a modified basis, you may be entitled to wage loss. This is generally calculated by multiplying the difference between your average weekly wage and your earnings during modified duties times two thirds. This is subject to the benefit minimums and maximums set by the California Legislature. Temporary disability benefits are payable within 14 days of the date of injury or knowledge of the injury. Subsequent payments are due every 14 days. For injuries occurring on or after 1/1/08, no more than 104 weeks of temporary disability are payable within 5 years from the date of injury. For longer term conditions (hepatitis B &C, amputations, severe burns, HIV, high velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis, and chronic lung disease) no more than 240 weeks within five years from the date of injury are payable. You may be eligible for state disability benefits from the Employment Development Department (EDD) if TD benefits are stopped, delayed, or denied. There are time limits so contact EDD for more information.

Permanent Disability (PD) Benefits:

You may be entitled to payments if your physician says your injury has limited your ability to work. The permanent disability rate is calculated by multiplying your average weekly wage by two thirds, subject to statutory minimums and maximums. The amount of permanent disability or impairment may depend on your doctor's opinion, as well as your age, occupation type of injury and date of injury. If you have permanent disability or your claims examiner suspects you have permanent disability, a letter will be sent to you explaining your benefits, including the estimate or total value of permanent disability, weekly payment amount, how the benefit was calculated, and all of your related rights under the California Labor Code, including your right to object to the report upon which the determination is being based. Permanent Disability benefits are payable within 14 days of the last payment of temporary disability benefits or after you physician indicates there is permanent disability. The benefit is payable every fourteen days.

Supplemental Job Displacement Benefit:

You may be entitled to a nontransferable voucher payable to a state approved school. To qualify, your injury must result in a permanent impairment and your employer is unable to offer modified or alternative work within 60 days of receipt of a report asserting that all medical conditions have reached maximum medical improvement. If your employer does not offer a modified or alternate job within 60 days of determination of maximum medical improvement, you may chose to receive a nontransferable voucher to use at a state accredited school for education-related retraining or skill replacement. If you qualify for the supplemental job displacement benefit, your claims examiner will provide a voucher for up to $6,000.00.

Return to Work Fund

If your injury results in permanent impairment and it is determined that the amount awarded is disproportionately low in comparison to your loss of earnings, you may be

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entitled to additional compensation. A fund was established to supplement permanent impairment benefits under specific circumstances. This fund is administered by the Division of Workers Compensation. Your examiner can assist in directing you to the correct resource to determine eligibility.

Death Benefits:

Death benefits are paid to dependents of a worker who dies from a work-related injury or illness. The benefit is calculated and paid in the same manner as temporary disability. This benefit is paid at a minimum rate of $224 per week. The death benefit rates are set by state law and the amount depends upon the number of dependents. If dependent minor children are involved, death benefits are payable at least until the youngest child reaches majority age. Burial expenses are also provided under this benefit.

Report Your Injury:

Report the injury immediately to your core leader.

You can also report your own claim via the HR Portal.

For any questions please contact: Anna Cabrera,

Workers' Compensation Consultant at (425) 525-5328

Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for your alleged injury and shall be liable for up to ten thousand dollars ($10,000) in treatment until the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($ 10,000). If your claim is denied, you have the right to appeal the decision within one year of the date of injury.

Discrimination:

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

Questions?

If you have questions, see your employer or the claims examiner who handles workers' compensation claims for your employer.

Claims Administrator:

Sedgwick Claims Management Services, Inc.

Address: P.O. Box 14442

City: Lexington State: KY Zip: 40512-4442

Phone: 800-854-6188

The employer is insured for workers' compensation by:
PHS is Self-Insured.

How do I locate information regarding my employer's current workers' compensation carrier?

For information regarding your employer's workers' compensation carrier, please visit the below website.

https://www.caworkcompcoverage.com

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

You can get free information from a State Division of Workers' Compensation Information & Assistance Officer.

The nearest Information & Assistance Officer is at:
Please refer to the attached I&A Office directory for the nearest location.

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

False claims and false denials:

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

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

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Contact the Information & Assistance Unit:

- By phone at **1-800-736-7401** -- For recorded information that helps injured workers, employers and others understand California's workers' compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers (***Asista a un seminario para trabajadores lesionados***)
- By calling or going in person to a local Information & Assistance Unit office:

Anaheim 1065 N. PacifiCenter Drive Anaheim 92806-2141 (714) 414-1801	**Oxnard** 1901 N. Rice Avenue, Ste. 200 Oxnard, CA 93030-7912 (805) 485-3528	**San Francisco** 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	**Pomona** 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	**San Jose** 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292
Eureka * Satellite office 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	**Redding** 250 Hemsted Dr 2nd Floor, Ste B Redding, CA 96002- 9040 (530) 225-2047	**San Luis Obispo** 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401-8736 (805) 596-4159
Fresno 2550 Mariposa Mall, Room 5005 Fresno, CA 93721-2219 (559) 445-5355	**Riverside** 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	**Santa Ana** 605 W Santa Ana Blvd, Bldg 28, Room 451 Santa Ana, CA 92701-4070 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	**Sacramento** 160 Promenade Circle, Suite 300 Sacramento, CA 95834-2962 (916) 928-3158	**Santa Barbara** * Satellite office 130 E Ortega St Santa Barbara, CA 93101-7538 (805) 568-1295
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-1954 (213) 576-7389	**Salinas** 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	**Santa Rosa** 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Marina del Rey 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	**San Bernardino** 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	**Stockton** 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Oakland 1515 Clay Street, 6th floor Oakland, CA 94612-1519 (510) 622-2861	**San Diego** 7575 Metropolitan Drive, Suite 202 San Diego, CA 92108-4424 (619) 767-2082	**Van Nuys** 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

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DWC FORM 9783 (July 1, 2014) PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) if:

- On the date of your work injury you have health care coverage for injuries/illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

EMPLOYEE

You (the employee) sign this section.

Employer _____

Employee Name* _____

_____

Employee ID#* _____

Date of Hire _____

Date of Birth _____

Address _____

City _____

St, Zip _____

In the event of any on-the-job, work-related injury, I request that I be treated by my personal physician.

Signature X _____

Date _____

PHYSICIAN

We cannot process this form without the fields marked bold with an asterisk.

Please PRINT clearly. _____

Physician First Name* _____

Physician Last Name* _____

Street Address* of the physician's practice _____

City* _____

St, Zip* _____

Telephone Number of the physician's practice (_ _ _) _ _ _-_ _ _ _

Group Name: _____

CA License _____

I agree to this Predesignation:

Physician Signature X _____

Date of Acceptance _____

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

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