

**All Personnel**

BP 4157.1

4257.1

**WORK-RELATED INJURIES**

4357.1

The Tuolumne County Superintendent of Schools desires to provide its employees with insurance and workers' compensation benefits in accordance with law. The County Superintendent or designee shall develop an efficient claims handling process in order to reduce costs and facilitate employee recovery.

- (cf. 3320 - Claims and Actions Against the County Office)*
- (cf. 4032 - Reasonable Accommodation)*
- (cf. 4113.4/4213.4/4313.4 - Temporary Modified/Light-Duty Assignment)*
- (cf. 4154/4254/4354 - Health and Welfare Benefits)*
- (cf. 4157/4257/4357 - Employee Safety)*
- (cf. 4157.2/4257.2/4357.2 - Ergonomics)*
- (cf. 4161.11/4361.11 - Industrial Accident/Illness Leave)*
- (cf. 4261.11 - Industrial Accident/Illness Leave)*

An employee shall report any work-related injury or illness to Company Nurse on Call as soon as practicable. Upon learning of an injury, a supervisor shall promptly report the incident to the County Superintendent or designee and the insurance carrier as appropriate.

The County Superintendent or designee shall ensure that every new employee is notified of his/her right to receive workers' compensation if injured at work and that injured employees are given notice of rights in accordance with law.

The County Superintendent or designee shall ensure that notifications regarding workers' compensation are posted in accordance with law.

*Legal Reference:*

EDUCATION CODE

- 1252 Group workers' compensation*
- 1297 County employee for purposes of workers' compensation*
- 44984 Industrial accident and illness leaves, certificated employees*
- 45192 Industrial accident and illness leaves, classified employees*

LABOR CODE

- 3200-4855 Workers' compensation, especially:*
- 3550-3553 Employee notice*
- 3600-3605 Conditions of liability*
- 3760 Report of injury to insurer*
- 4600 Provision of medical and hospital treatment by employer*
- 4906 Disclosures and statements*
- 5400-5413 Notice of injury or death*
- 6409.1 Reports*

CODE OF REGULATIONS, TITLE 8

- 15596 Notice of employee rights*

*Management Resources:*

WEB SITES

- California Department of Industrial Relations: <http://www.dir.ca.gov>*

Policy  
adopted: May 30, 2008

**TUOLUMNE COUNTY SUPERINTENDENT OF SCHOOLS**  
Sonora, California

**All Personnel**

AR 4157.2(a)

4257.2

**ERGONOMICS**

4357.2

To minimize employees' risk of repetitive motion injuries (RMIs), the Tuolumne County Superintendent of Schools or designee shall implement an ergonomics program whenever two or more RMIs from an identical work activity have been reported by Superintendent employees within a 12-month period beginning July 3, 1997. In addition, all reported injuries must satisfy all of the following conditions: (8 CCR 5110)

1. The RMIs were predominantly caused (i.e., 50 percent or more) by a repetitive job, process or operation.
2. The employees incurring the RMIs were performing a job process or operation of identical work activity. Identical work activity means that the employees were performing the same repetitive motion task, such as similar word processing, assembly or loading tasks.
3. The RMIs were musculoskeletal injuries that a licensed physician objectively identified and diagnosed.

The County Superintendent or designee shall ensure that the ergonomics program be designed to minimize RMIs in accordance with law. The program shall be composed of the following components: (8 CCR 5110)

1. Worksite evaluation

Each job, process or operation of identical work activity, or a representative number of such jobs, processes or operations of identical activities, shall be evaluated for exposures which have caused RMIs.

2. Control of exposures which have caused RMIs

Any exposures that have caused RMIs shall, in a timely manner, be corrected or, if not capable of being corrected, be minimized to the extent feasible. The County Office shall consider engineering controls, such as work station redesign, adjustable fixtures or tool redesign, and administrative controls such as job station, work pacing or work breaks.

3. Training

Employees shall be provided training that includes an explanation of:

- a. The County Office program
- b. The exposures that have been associated with RMIs
- c. The symptoms and consequences of injuries caused by repetitive motion

**ERGONOMICS** (continued)

- d. The importance of reporting symptoms and injuries to the employer
- e. Methods used by the County Office to minimize RMIs

(cf. 4157 /4257/4357 - *Employee Safety*)  
(cf. 4157.1/4257.1/4357.1 - *Work-Related Injuries*)

*Legal Reference:*

EDUCATION CODE

44984 *Industrial accident and illness leaves, certificated employees*

45192 *Industrial accident and illness leaves, classified employees*

GOVERNMENT CODE

21153 *Employer not to separate for disability members eligible to retire*

LABOR CODE

142.3 *Adoption, amendment or repeal of standards and orders*

3200-4855 *Workers' compensation, especially:*

3550-3553 *Employee Notice*

3600-3605 *Conditions of liability*

3760 *Report of injury to insurer*

4600 *Provision of medical and hospital treatment by employer*

4906 *Disclosures and statements*

5400-5404 *Notice of injury or death*

6303 *Place of employment; employment*

6305 *Occupational safety and health standards; special orders*

6310 *Retaliation for filing complaint prohibited*

6357 *Standards for workplace ergonomics*

6401.7 *Injury prevention programs*

6409.1 *Reports*

CODE OF REGULATIONS, TITLE 8

3203 *Injury and Illness Prevention Program*

5110 *Repetitive motion injuries*

**CATASTROPHIC LEAVE**

1. An employee who is, or whose family member is, suffering from a catastrophic illness or injury may receive sick leave credits from the catastrophic leave bank.
2. “Catastrophic illness” or “injury” means an illness that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee’s family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member, and taking extended time off work creates a financial hardship for the employee because he/she has exhausted all of his/her sick leave and other paid time off. (EC 44043.5)
3. Upon requesting donations under the program, the employee shall provide verification of the catastrophic illness or injury. (EC 44043.5)
4. The Superintendent or designee shall determine:
  - a. That the employee is unable to work due to the employee’s or his/her family member’s catastrophic illness or injury, and
  - b. That the employee has exhausted all accrued paid leave credits. (EC 44043.5)
5. When the above verification and determinations are made, the Superintendent or designee may approve the transfer of accrued sick leave credits. (EC 44043.5)
6. The Superintendent or designee shall inform employees of the means by which donations may be made in response to the employee’s request.
7. Any employee, upon written notice to the office, may donate accrued sick leave credits to the requesting employee at a minimum of two hours and a maximum of three work days. All transfers or eligible leave credit shall be irrevocable. (EC 44043.5)
8. To ensure that employees retain sufficient accrued sick leave to meet needs that normally arise, donors shall not reduce their accumulated sick leave to fewer than twenty (20) days.
9. Benefitting employees may use donated leave credits for a maximum of 60 days per year.
10. An employee who receives paid leave pursuant to this program shall use any leave credits that he/she continues to accrue on a monthly basis before receiving paid leave pursuant to this program. (EC 44043.4)
11. The Superintendent or designee shall ensure that all donations are confidential.

**TUOLUMNE COUNTY SUPERINTENDENT OF SCHOOLS**  
Employee Request to Receive Donation of Catastrophic Leave

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Position: \_\_\_\_\_ Work Location: \_\_\_\_\_

I hereby declare that I have or soon will have exhausted all earned sick leave, vacation leave, and other paid time off and I am requesting catastrophic sick leave for reasons and due to circumstances as follows:

Illness/Injury affects: Self  Qualifying Family Member   
Spouse \_\_\_\_\_ Child/Step Child \_\_\_\_\_  
Parent \_\_\_\_\_ Sibling \_\_\_\_\_  
Other permanent household member \_\_\_\_\_

Describe the nature of the illness or injury:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate the anticipated duration of this illness or injury:  
\_\_\_\_\_

Describe the nature and extent of the resulting financial hardship should you have to take time off without pay:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I am unable to work and must take time off due to a catastrophic illness or injury to the above-mentioned family member or myself. I have been given a copy of the Tuolumne County Superintendent of Schools Administrative Regulation and understand the terms and conditions under which I am requesting catastrophic leave. I have attached a letter of verification signed and dated by the treating physician, which indicates the incapacitating nature of the illness or injury and an estimated time that I will be unable to work.

Date: \_\_\_\_\_  
\_\_\_\_\_  
(Signature of Employee or Authorized Representative)  
\_\_\_\_\_  
(Print name of Employee or Authorized Representative)  
\_\_\_\_\_  
(Print Authorized Representative's relationship to Employee)

**OFFICE APPROVAL:**

The above request for donation of catastrophic leave is approved as requested and upon authorized donation, catastrophic leave donated shall be made available.

\_\_\_\_\_  
Date (Personnel Director's Signature)

**TUOLUMNE COUNTY SUPERINTENDENT OF SCHOOLS**  
Employee Request to Donate Catastrophic Leave

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print)

Position: \_\_\_\_\_ Work Location: \_\_\_\_\_

I hereby request to donate sick leave to a Catastrophic Leave Bank to be used due to a catastrophic illness/injury.

Deduct from my earned sick leave \_\_\_\_\_ hours (2 hours minimum not to exceed 24 hours)  
(Employee may not reduce their earned sick leave below 20 days.)

I fully understand and agree that by exercising my option of donating such accumulated sick leave and/or hours as requested herein that:

1. After my donation my earned sick leave will be at 20 days or greater.
2. I will no longer have any right to any of my donated sick leave at any future time under any circumstances: (a) once the donation is approved by the Office; (b) no matter what the need for current catastrophic leave may prove to be once my donation is approved by the Office.

The Office specifically has not made any statements, representations, nor taken any actions, nor in any way influenced my freely taken decision to donate sick leave as requested. I assume all risks associated with my donation as provided herein and take full responsibility regarding any and all loss of benefits, penalties, liabilities or obligations I may have, if any, for matters including those relating to: State or federal income taxes; State or federal gift taxes; Retirement benefits under STRS or PERS; Social security benefits; Difference pay under Education Code section 4977; Transfer to another educational agency under Education Code sections 44979, 44980 or 44982; Industrial accident leave pursuant to Education Code section 44984; Disability allowances under Education Code section 44986; and any other leaves and/or benefits.

Further, I assume all risks and take full responsibility and otherwise hold the Office harmless for any and all statements, actions and representations made to me regarding the above named employee's need for donated catastrophic leave no matter what the source or its apparent reliability.

Dated: \_\_\_\_\_  
(Signature of Employee Donor)

**RETURN TO THE HUMAN RESOURCES DEPARTMENT**

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**AUTHORIZATION:**

The above donation of catastrophic leave is

- Approved as requested
- Denied. Will reduce accumulated sick leave to fewer than 20 days.

Date Transfer Posted: \_\_\_\_\_ By: \_\_\_\_\_

\_\_\_\_\_  
Human Resources Director Date