PALOMAR COLLEGE
Learning for Success

Human Resource Services
Request/Recommendation for Volunteer Service

Section A – Department completes

Volunteer's Name:	Prior Volunteer? ☐ Yes ☐ No	
Social Security # or School ID #:		
Department:		
Description of duties volunteer will perform:		
Expected dates of service (MM/DD/YY):	From:	To:
Number of hours:		☐ daily ☐ weekly ☐ monthly

Required to drive fleet vehicle ☐ yes ☐ no Required to drive maintenance cart ☐ yes ☐ no

I recommend that the above named individual be approved to perform these services.

Supervisor Name and Title (Print) _____ Supervisor Signature _____ Date _____

Department Dean/Director Signature _____ Date _____ Vice President Signature _____ Date _____

Section B – Volunteer completes

I, _____, request and acknowledge that the Palomar Community College District shall consider my volunteer services to be deemed as unpaid. I understand that Palomar College shall have the right to check my Department of Motor Vehicle driving record. This is because certain District volunteers may be called upon in their status to provide transportation or operate District vehicles. I also understand that a fingerprint check and background investigation similar to a regular school employee will be conducted. In return, I acknowledge that if I am injured while working on behalf of the District, that I will be covered by the District's Workers' Compensation coverage. I understand that my volunteer status does not begin until I have signed in on the work site Volunteer Register, and that I am responsible for properly signing in and out each day. Further, I affirm that I will complete a TB skin test/TB Risk Assessment and submit results to the College before beginning volunteer services.

Legal Name (Print) _____ Signature _____

Address _____ City/State/Zip _____

Email Address: _____ Primary Phone _____
Will be used as primary mode of communication during pre-volunteer process.

Emergency Contact _____ Relationship _____ Phone _____

If volunteer is a minor: I have read and understand the above conditioned consent to that above individual's participation as an unpaid volunteer of Palomar College.

Parent/Guardian Name (Print) _____ Signature _____ Date _____

Section C – For HR official use

Reviewed by Human Resource Services

Signature _____ Date _____ Requirements Completed on _____

☐ Approved ☐ Disapproved

Human Resource Services

Worker's Compensation Notice

I, _____ have received the following materials regarding
(Please Print)
Worker's Compensation:

- Notice to Employees
- Covered Employee Notification of Rights Material - PRIME Advantage Medical Network
- New Hire Pamphlet
- Personal Physician Request Form
- Personal Physician Acknowledgement Form

_____ _____
Employee's Signature Date

Form122012

Palomar College

workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O), or medical group, if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated**, **personal physician**, **the physician must agree, in writing, to treat you for a work related injury,** must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, in **writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE NAME: _____

❑ **I acknowledge receipt of this form and elect not** to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

❑ **If I am injured on the job, I wish to be treated by my personal physician***:

Name of Physician or Medical Group _____ Phone Number _____

Address _____

***This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury.
The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other **written** documentation of the physicians' agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: _____

❑ ***I agree to treat*** **the above named employee in the event of an industrial accident or injury**. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

❑ ***I do not agree*** **to treat the above employee in the event of an industrial accident or injury.**

❑ ***I do not qualify*** **as the employees' personal physician**. I am not an M.D. or D.O. or do not meet the criteria outlined above.

_____ _____

(Physician or Designated Employee of the Physician or Medical Group) Date

Please return completed form to:

Palomar College, 1140 W. Mission Rd., San Marcos, CA 92069 (Fax 760.761.3530)

Palomar College
workers' compensation
Notice of Personal Chiropractor or Personal Acupuncturist

If your employer does not participate in a Medical Provider Network (MPN) you may be able to change your treating physician to your personal chiropractor or acupuncturist. Generally your employer, or Keenan, has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your employer, or Keenan, initiates treatment you may, upon request, have your treatment transferred to your personal chiropractor or acupuncturist. To be eligible you must notify your employer in writing prior to being injured.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

Chiropractor or Acupuncturist Name: _____

Address: _____

Phone Number: _____

Employee Name: _____

Employee Address: _____

Employee Signature: _____ Date: _____

Please return completed form to:

Palomar College Human Resources
1140 West Mission Road, San Marcos, CA 92069

March 2014

new hire pamphlet

If a work injury occurs

California law guarantees certain benefits to employees who are injured or become ill because of their jobs.

Any job related injury or illness is covered. Types of injuries include, but may not be limited to, strains, sprains, cuts, cumulative or repetitive traumas, fractures, illnesses and aggravations. Some injuries from voluntary, off duty, recreational, social or athletic activity may not be covered. Check with your supervisor or Keenan & Associates if you have any questions.

All work related injuries must be reported to your supervisor immediately. 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.

It is a misdemeanor for an employer to discriminate against workers who are injured on the job or who testify in another employee's case. Any such employee may be entitled to compensation, reinstatement and reimbursement for lost wages and benefits.

Workers' compensation benefits include

Medical Care – All medical treatment, without a deductible or dollar limit. For dates of injury on or after 1/1/04 there is a limit of 24 chiropractic, 24 physical therapy and 24 occupational therapy visits. However this limit does not apply for post surgical treatments. Costs are paid directly by Keenan & Associates, through your employers workers' compensation program, so you should never see a bill.

If emergency treatment is required go to the nearest emergency room or contact 911.

Keenan & Associates will arrange medical treatment, often by a specialist for the particular injury. Preferred Provider Networks may be utilized for physicians as well as medical care centers.

If you have health care coverage you are eligible to treatment with your personal physician or medical group should you become injured on the job. If you are eligible, **before you are injured**, you must notify your employer **in writing** and provide your employer **written** documentation from your personal physician or medical group that they agree to be predesignated. Your personal physician must be your regular primary care physician who previously directed your medical treatment, who retains your medical history and records. You may only predesignate your primary care physician if they are a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, or pediatrician. Your personal physician may be a multispecialty medical group composed of licensed doctors or osteopathy providing medical services predominantly for non-occupational illness and injuries.

Your employer may be using a Medical Provider Network (MPN), which is a selected group of health care providers to provide treatment to workers injured on the job. If you have predesignated a 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 and MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer or Keenan & Associates. 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 on reverse side.

If your employer **does not** participate in a Medical Provider Network (MPN) you may be able to change your treating physician to your personal chiropractor or acupuncturist. Generally your employer, or Keenan, has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your employer, or Keenan, initiates treatment you may, upon request, have your treatment transferred to your personal chiropractor or acupuncturist. To be eligible you must notify your employer **in writing prior to being injured**. However, a chiropractor cannot be your treating physician after receiving 24 chiropractic office visit.

Your employer will provide you with a form to use an optional method to predesignate your personal physician.

Contact Keenan & Associates if you plan to change physicians at any time.

Payment for Lost Wages - If you're temporarily disabled by a job injury or illness, you'll receive tax-free income until your doctor says you are able to return to work. Payments are two-thirds of your average weekly pay, up to

Keenan & Associates

a maximum set by state law. Payments aren't made for the first three days unless you are hospitalized in an inpatient basis or unable to work more than 14 days.

If the injury or illness results in permanent disability, additional payments will be made after recovery. If the injury results in death, benefits will be paid to surviving, eligible dependents.

Rehabilitation – For dates of injury on or after 1/1/04 - you may be entitled to a ***Supplemental Job Displacement Voucher***, which entitles you to a voucher for educational training.

How to obtain additional information

Contact your employer representative or Keenan & Associates if you have questions about workers' compensation benefits. You may also contact an Information and Assistance Officer at the State Division of Workers' Compensation. You can consult an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at 415-538-2120.

Department of Workers' Compensation Information and Assistance Offices

You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. The phone numbers are listed below. Hear recorded information by calling toll-free 800-736-7401 or visit www.dwc.ca.gov.

Anaheim	714-414-1804
Bakersfield	661-395-2514
Eureka	707-441-5723
Fresno	559-445-5355
Goleta	805-968-4158
Long Beach	562-590-5001
Los Angeles	213-576-7389
Marina Del Rey	310-482-3858
Oakland	510-622-2861
Oxnard	805-485-3528
Pomona	909-623-8568
Redding	530-225-2047
Riverside	951-782-4347
Sacramento	916-928-3158
Salinas	831-443-3058
San Bernardino	909-383-4522
San Diego	619-767-2082
San Francisco	415-703-5020
San Jose	408-277-1292
San Luis Obispo	805-596-4159
Santa Ana	714-558-4597
Santa Rosa	707-576-2452
Stockton	209-948-7980
Van Nuys	818-901-5367

Keenan & Associates adjusting locations

Torrance
800-654-8102

Eureka
707-268-1616

Pleasanton
925-225-0611

Rancho Cordova
800-343-0694

Redwood City
650-306-0616

Riverside
800-654-8347

San Jose
800-334-6554

Anyone who knowingly files or assists in the filing of a false workers' compensation claim may be fined up to $150,000 and sent to prison for up to five years.
[Insurance Code Section 1871.4]

December 2012

Keenan & Associates

School Staff & Volunteers: Tuberculosis Risk Assessment

Job-related requirement for child care, pre-K, K-12, and community colleges

The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading TB. Use of this risk assessment is required in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055 and 121525, 121545, and 121555.

The law requires that a health care provider administer this risk assessment. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. Any person administering this risk assessment is to have training in the purpose and significance of the risk assessment and Certificate of Completion.

Name of Employee/Volunteer Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Infection or Disease (Check appropriate box below)

☐ **Yes**

If there is a documented history of positive TB test (infection) or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

Risk Factors for Tuberculosis (Check appropriate boxes below)

If any of the 5 boxes below are checked, perform a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA). Re-testing with TST or IGRA should only be done in persons who previously tested negative, and have new risk factors since the last assessment. A positive TST or IGRA should be followed by a chest x-ray, and if normal, treatment for TB infection considered. (Centers for Disease Control and Prevention [CDC]). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers.* 2013)

☐ **One or more signs and symptoms of TB:** prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue.

Evaluate for active TB disease with a TST or IGRA, chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

☐ **Close contact** to someone with infectious TB disease at any time

☐ **Foreign-born** person from a country with an elevated TB rate

Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe. IGRA is preferred over TST for foreign-born persons

☐ **Consecutive travel or residence of ≥ 1 month** in a country with an elevated TB rate

Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.

☐ Volunteered, worked or lived in a **correctional or homeless** facility

School Staff & Volunteers: Tuberculosis Risk Assessment User Guide

Job-related requirement for child care, pre-K, K-12, and community colleges

Background

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current federal Centers for Disease Control and Prevention (CDC) recommendations for targeted TB testing. Enacted laws, **AB 1667,** effective on January 1, 2015, **SB 792** on September 1, 2016, and **SB 1038** on January 1, 2017, require a tuberculosis (TB) risk assessment be administered and if risk factors are identified, a TB test and examination be performed by a health care provider to determine that the person is free of infectious tuberculosis. The use of the TB risk assessment and the Certificate of Completion, developed by the California Department of Public Health (CDPH) and California TB Controllers Association (CTCA) are also required.

AB 1667 impacted the following groups on 1/1/2015:

1. Persons employed by a K-12 school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)
2. Persons employed, or employed under contract, by a private or parochial elementary or secondary school, or any nursery school (California Health and Safety Code, Sections 121525 and 121555).
3. Persons providing for the transportation of pupils under authorized contract in public, charter, private or parochial elementary or secondary schools (California Education Code, Section 49406 and California Health and Safety Code, Section 121525).
4. Persons volunteering with frequent or prolonged contact with pupils (California Education Code, Section 49406 and California Health and Safety Code, Section 121545).

SB 792 impacted the following group on 9/1/2016:

Persons employed as a teacher in a child care center (California Health and Safety Code Section 1597.055).

SB 1038 impacts the following group on 1/1/2017:

Persons employed by a community college district in an academic or classified position (California Education Code, Section 87408.6).

Testing for latent TB infection (LTBI)

Because an interferon gamma release assay (IGRA) blood test has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the tuberculin skin test (TST) in these persons. Most persons born outside the United States have been vaccinated with BCG.

Repeat risk assessment and testing

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray should be performed at initial hire. Once a person has a documented positive test for TB infection that has been followed by a chest x-ray (CXR) that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required.

Repeat risk assessments should occur every four years (unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk assessment. Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a person with active TB can be a sign of extensive disease and poor outcome.

Symptoms of TB should trigger evaluation for active TB disease

Persons with any of the following symptoms that are otherwise unexplained should be medically evaluated: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

TB infection treatment is recommended

Shorter regimens for treating LTBI have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Shorter regimens are preferred in most situations. Drug-drug interactions and contact to drug resistant TB are frequent reasons these regimens cannot be used.

Please consult with your local public health department on any other recommendations and mandates that should also be considered.

BCG=Bacillus Calmette-Guérin; TST= tuberculin skin test; IGRA= Interferon gamma release assay (e.g., QuantiFERON-TB Gold, T-SPOT.TB)

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____
Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

Telephone and FAX:

PALOMAR COLLEGE
Learning for Success

Volunteer Register Form

Volunteer Name: _____

Supervisor: _____ Department: _____

Reporting Month: _____ Year: _____

Must be completed and returned to Human Resource Services.

Date	Work Location	Time In	Time Out

Volunteer Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____