Dalrada Financial Corporation | 9449 Balboa Avenue, Suite 210 San Diego, CA 92123
P: 858.277.5300 F. 858.427.8700 www.dalrada.com

Reporting Work-Related Injuries

1. **CALL DALRADA IMMEDIATELY**

Contact	Bill Hesselbacher, Workers Compensation Manager
Phone	(858) 427-8765
Fax	(858) 277-3448
Email	bhesselbacher@dalrada.com

   If it is a medical emergency, get necessary medical care immediately, then notify Dalrada. During non-business hours, leave a message describing injury, treatment, and telephone number where you can be reached during normal business hours.

2. **MEDICAL TREATMENT**

   Dalrada will coordinate with workers compensation insurance carrier to arrange a provider, typically at a US Healthworks, Concentra, Kaiser, or Work Med Occupational Care Clinic, to treat you. During non-business hours, please refer to the list of selected providers to see where to receive medical treatment in your area.

3. **HELPFUL INFORMATION TO GIVE TO PROVIDER**

Employer Name:	Dalrada Financial
Employer Address:	9449 Balboa Ave., Ste. 210 San Diego, CA 92123
Employer Telephone:	(858) 427-8765
Employer Fax:	(858) 277-3448

4. **COMPLETE INJURED EMPLOYEE PACKET**

   Please fill out the enclosed Injured Employee Packet and fax, to Attn: Bill Hesselbacher, at (858) 277-3448. Dalrada will provide the claim form to you following notification of your injury. Please complete and return to Dalrada immediately.

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INJURED EMPLOYEE PACKET

For a work-related illness or injury, the injured employee must fill out the following forms ASAP:

1.) Workers' Compensation Claim Form (DWC1)
2.) Injury Incident Statement
3.) Witness Statement
4.) Medical History Information
5.) Authorization to Release Records
6.) Temporary Modified Work Offer – if work status indicates
    a. Office Helper
    b. Production
7.) Refusal to File

Note:
If employee fills out form #7, employee does not need to fill out #1 – 6.

If employee fills out form #1 – 6, employee does not need to fill out #7.

CALL DALRADA FINANCIAL IMMEDIATELY WHEN AN INJURY OCCURS

858.427.8700

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for 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).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

You can consult with 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 or go to their web site at **www.californiaspecialist.org**.

impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de noche, o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el/la administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador *(Division of Workers' Compensation – DWC)*, o puede escuchar información grabada, así como una lista de oficinas locales, llamando al **(800) 736-7401**. Ud. también puede ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

PRINT CLEAR

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

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

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

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

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

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

7/1/04 Rev.

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Personal Injury Incident Report

DIRECTIONS: Please fill out COMPLETELY for any work-related injury or illness even if no medical treatment is needed at time of accident. If a doctor is not seen at the time of injury, but medical treatment is sought following that time, please notify Dalrada immediately at **858-427-8700** to avoid delay in payment of medical expenses.

1. Name _____ 2.Soc. Sec. No._____
3. Home Address_____
4. Phone _____ 5. Job Title_____ 6. Division_____
7. Date of Birth_____ 8. Date of Hire_____ 9. Pay Rate _____
10. Date/Time of Injury_____ AM/ PM (Please Circle One)
11. Place of Injury (Include Address) _____
12. Did you miss work after your injury? ___ Yes ____ No Date(s) _____
13. Have you returned to work? ____ Yes ____ No Date Returned_____
14. Did you complete an Employee's Claim for Worker's Compensation Benefits form? Yes/ No
15. How did the accident happen? _____

_____

_____

16. Describe in detail the nature of the injury. What part of the body was affected? _____

_____

_____

17. Did you receive care for your injury or illness? _____ Yes _____ No

Please state the name of the doctor, facility, and the date you received treatment. _____

_____ Date _____

18. If another Person was responsible for the accident, give name and address_____

_____

_____

19. List names of any witnesses to the accident_____

_____

ANY EMPLOYEE WHO IS SEEN BY A DOCTOR FOR A WORK RELATED INJURY OR ILLNESS SHALL HAVE THE ATTENDING PHYSICIAN COMPLETE A "MEDICAL RELEASE FORM". EMPLOYEE SHALL DELIVER THE COMPLETED FORM PRIOR TO RETURNING TO WORK. NO EMPOYEE WHO HAS BEEN SEEN BY A DOCTOR FOR A WORK-RELATED INJURY OR ILLNESS MAY RETURN TO WORK WITHOUT A COMPLETED MEDICAL RELEASE FORM AND RECEIPT OF ADMINISTERED DRUG TEST.

YOU MUST ALSO COMPLETE AN EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS FORM.

_____ _____

Date Signed Signature of Employee

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Supervisor's Report of Accident Investigation

Describe the incident which caused the injury:_____

_____

_____

Did the injury occur during the course and scope of the employee's duties? ____ Yes ____ No

Was first aid administered? ____ Yes ____ No If yes, by whom?_____

Do you concur with the employee's account of the accident? _____ Yes _____ No

If no or unsure, please explain _____

_____

_____

PLEASE CHECK THOSE WHICH APPLY AND REPORT OTHER FINDINGS OF YOUR INVESTIGATION BELOW. The purpose of this is not to fix blame, but rather to determine what can be done to prevent a similar incident from occuring again.

UNSAFE PRACTICE

_____ Operating without authority
_____ Making safety devices inoperable
_____ Improper loading or placement
_____ Servicing equipment in motion
_____ Alcohol/Drugs
_____ Failure to warn or secure
_____ Using defective equipment
_____ Improper lifting
_____ Not listed, briefly describe:_____
_____ Inattention
_____ Overexertion
_____ Operating at improper speed
_____ Failure to use personal protective equipment
_____ Improper position
_____ Horseplay
_____ Failure to comply with rules
_____ No unsafe practice

UNSAFE CONDITION

_____ Inadequate warning system
_____ Hazardous atmospheric conditions, weather, gases, dusts, fumes, vapors
_____ Defective equipment, tools, material
_____ Fire/explosive hazard
_____ Excessive noise
_____ Not listed, describe briefly:_____
_____ Hazardous arrangement
_____ Poor housekeeping
_____ Inadequate lighting or ventilation
_____ Improper dress or apparel
_____ Assualt/hostile person
_____ No unsafe condition

CAUSE OF ACCIDENT. What acts, failures to act and/or conditions contributed most directly to the accident?_____

_____

_____

_____

CORRECTIVE ACTION. What action has been taken, will be taken, or is recommended to prevent a reoccurrence?_____

_____

_____

_____

Supervisor Name _____
Supervisor Signature_____ Date_____

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WITNESS STATEMENT

Name of Witness_____ Department_____

Client Company_____

Name of Employee_____ Date of Incident_____

Were you in the area where the accident happened? Yes No

Did you see the accident happen? Yes No

Where exactly did the accident occur? _____

What did you see and/or hear? When did you hear or see, give the date.

_____
_____
_____
_____

What part of the body was injured? _____

Was the employee using a tool or piece of machinery when the incident happened? Yes No

Please describe: _____

Have you heard the employee talk about a similar incidents? Yes No

If so, explain: _____

What can be done to prevent a similar incident in the future?

_____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____

Witness Signature_____ Date_____

Medical History Information

Name:	Social Security Number	Date of Birth:	Age: Sex: ☐ M ☐ F
Address:		Personal Physician	

This information is kept confidential and is used for purposes of assisting in cases of medical emergencies, injury prevention and management. Information should be given only after an offer of employment has been made.

1. HEART CONDITIONS Please answer the following:

Have you **ever** been treated or told by a physician that you have a heart condition? ☐ Yes ☐No
Have you **ever** suffered from high blood pressure? ☐ Yes ☐No
Have you **ever** experienced shortness of breath, fainting, dizzy spells or chest pain? ☐ Yes ☐No
Have you **ever** been diagnosed with any other vascular or circulatory condition? ☐ Yes ☐No
Do you have diabetes? ☐ Yes ☐No

If yes to any of the above, describe what and when? _____
If yes to any of the above, describe medical treatment you received? _____
If yes to any of the above, describe any restrictions or limitations you **now** have?

2. ENVIRONMENT RELATED/ ALLERGIES Please answer the following:

Have you **ever** had heat stress, heat exhaustion, frostbite or other problems associated with environmental conditions? (Circle those you have experienced) ☐ Yes ☐No
Have you **ever** had pain, reactions, ringing in your ears, eye or vision problems related to noise or dust? (Circle those you have experienced) ☐ Yes ☐No
Do you have any allergies? ☐ Yes ☐No

If yes, describe what and when? _____
If yes, describe medical treatment you received? _____
If yes, describe any restrictions or limitations you **now** have? _____

3. HEAD Please answer the following:

Have you **ever** had any head or brain conditions? ☐ Yes ☐No
Have you **ever** suffered from a stroke? ☐ Yes ☐No

If yes to any of the above, describe what and when? _____
If yes to any of the above, describe medical treatment you received?_____
If yes to any of the above, describe any restrictions or limitations you **now** have?

4. GASTRO-INTESTINAL /URINARY Please answer the following:

Have you ever suffered from any GI, stomach or urinary disorders? ☐ Yes ☐No

If yes, describe what and when? _____
If yes, describe medical treatment you received? _____
If yes, describe any restrictions or limitations you **now** have? _____

5. VISION AND HEARING Please answer the following:

Is your hearing sufficient to identify approaching vehicles or equipment that can not be seen? ☐ Yes ☐No
Have you **ever** had any corrections for hearing or vision? ☐ Yes ☐No
Have you **ever** been diagnosed with any hearing or sight impairment/loss? ☐ Yes ☐No

If yes to any of the above, describe what and when? _____
If yes to any of the above, describe medical treatment you received? _____
If yes to any of the above, describe any restrictions or limitations you **now** have? _____

6. HAND OR ARM USE Please answer the following:

Have you **ever** had pain, numbness, tingling, or problems with your hands, wrists, arms, shoulders or neck? ☐ Yes ☐No

If yes, describe what and when? _____
If yes, describe medical treatment you received? _____
If yes, describe any hands, wrists, arms, shoulders or neck restrictions or limitations you **now** have?

7. **UPPER BODY** Please answer the following:

Have you **ever** had pain, strain, sprain or problems with your back, shoulders, neck, chest or torso areas? ☐ Yes ☐No

If yes, describe what and when? _____

If yes, describe medical treatment you received? _____

If yes, describe any back, shoulders, neck, chest or torso-area restrictions or limitations you **now** have?

8. **LOWER BODY** Please answer the following:

Have you **ever** had pain, strains, sprains or problems with your legs, knees, feet or pelvic areas? ☐ Yes ☐No

If yes, describe what and when? _____

If yes, describe medical treatment you received? _____

If yes, describe any legs, knees, feet or pelvic area restrictions or limitations you **now** have?

9. **HAZARDOUS MATERIALS** Please answer the following:

Have you **ever** had pain, rashes, swelling reactions or problems related to hazardous chemicals? ☐ Yes ☐No

If yes, describe what and when? _____

If yes, describe medical treatment you received? _____

If yes, describe any restrictions or limitations you **now** have related to hazardous chemicals?

PLEASE ANSWER THE FOLLOWING QUESTIONS

10. Are you currently taking any medications? ☐ Yes ☐No If yes, please advise for what conditions:

_____

11. Are you presently under the care of a physician of any type for any physical ailment or illness.
☐ Yes ☐No If yes, please explain:

_____

12. Have you ever received medical or first-aid treatment for any injury or illness that occurred while you were on the job? ☐ Yes ☐No If yes, please explain:

_____

13. Have you ever been unable to work on a job or unable to perform an assigned task because of any medical reason? ☐ Yes ☐No If yes, please explain:

_____

MEDICAL RECORDS RELEASE

For purposes of assisting in medical emergency and injury claim prevention and management, I give my consent to any health care provider (hospital, clinic, medical office, physician, pharmacy, etc), insurance company, medical service company, or employer to disclose upon request to Dalrada or its representatives, any and all information concerning past, present and future medical conditions, evaluations or treatments including, but not limited to, claim reports, medical records, x-rays, all diagnostic tests and reports, consultations, examinations, prescriptions or treatment. This authorization applies to any prior or future employer, insurance carrier, government agency, Social Security Administration, Veterans Administration, or medical service provider of any type.

I recognize that the information disclosed may contain information that is protected by federal or state laws, and I specifically consent to the disclosure of such information relating to the diagnosis or treatment of any mental or psychiatric conditions or alcohol or drug abuse. A photocopy of this authorization shall be considered equally valid as the original. I understand and agree that falsification of information, misleading statements, misrepresentation, or omission of facts called for anywhere on this form is cause for dismissal regardless of when discovered. This release is valid for seven years from the date signed below or the date of my termination from employment with Dalrada, whichever is later.

The undersigned acknowledges that the medical history information provided on this document was requested by Dalrada subsequent to an offer and acceptance of employment.

Employee Signature	**Today's Date**

Dalrada Financial Corporation | 9449 Balboa Avenue, Suite 210 San Diego, CA 92123
P: 858.277.5300 F. 858.427.6700 www.dalrada.com

Authorization to Release Records

I give my consent to any health care provider (hospital, clinic, physician, or pharmacy), insurance company, client, or claims administrator to disclose upon request to Dalrada or its representatives, any and all information, including but not limited to, claim reports, hospital or medical records including history, x-ray, other diagnostic tests, consultants, examinations, prescriptions or treatment, relating to any illness or injury which I may have incurred or suffered. This information is being disclosed to the self-insured employer, Dalrada, or its representative to assist in determining the extent and nature of my eligibility for insurance related benefits.

This authorization applies to any prior employer, insurance carrier, the Social Security Administration, the Veterans Administration, and State or Federal public agency, all of whom may have records of my past or present physical or mental condition.

I recognize that the information disclosed may contain information that is protected by Federal and/or State law, and I specifically consent to the disclosure of such information relating to the diagnosis or treatment of any mental or psychiatric condition or alcohol and/or drug abuse. A photo-static copy of this authorization shall be considered as effective and valid as the original.

_____ _____

PRINT NAME DATE

_____

SIGNATURE OF EMPLOYEE

Dalrada Financial Corporation | 9449 Balboa Avenue, Suite 210 San Diego, CA 92123
P: 858.277.5300 F. 858.427.6700 www.dalrada.com

INJURED EMPLOYEE
TEMPORARY MODIFIED WORK OFFER
Office Helper (Office Clerical)

DATE: _____

EMPLOYEE: _____ SOCIAL SECURITY NUMBER_____

You have been offered a job at _____; starting on _____

working from _____ A.M./P.M. to _____A.M./P.M.

You will sort documents, file – alpha numeric, make copies, organize office supplies, faxing, mailing, labeling and general office support as requested by office Supervision. (Duties will not require repeated or extensive stooping, pulling, pushing, bending, reaching or lifting of objects over 10 pounds.)

While you are still recovering from your injury, Dalrada has made all provisions for temporary modified work. It has been determined that the above position will fit all limitations established by your treating physician during the recuperative period. If at any time you are asked to perform a task that does not fall within your restrictions, **call Dalrada immediately** for further instructions.

It is also required of you to call in when not planning on appearing for work. If you fail to call in and do not show up for work, it will be considered a voluntary quit and you will not be eligible for re-employment with Dalrada unless your treating physician concurrently determines and notifies us, by the end of the business day, that you cannot do the temporary modified work.

Management may designate work schedules and location. No overtime is allowed for modified duty positions. Employee is only paid for the hours worked.

Note: Modified duty positions fall under the same standards of work practices, policies and procedures as any other *(Client Company)* / Dalrada positions.

The Modified-Duty assignment is temporary. Our goal is to return you to your regular work assignment as soon as the doctor removes or reduces your physical limitations.

Nothing in this is document constitutes a guarantee of the continued employment or alters Dalrada policy of at-will employment, by which you or Dalrada may terminate employment at any time with or without cause.

Please sign below that you understand and agree with the above statements.

_____ _____
Employee Signature Date

_____
Employee Print Name

_____ _____
Dalrada Financial Representative Date

Copy: Employee

Dalrada Financial Corporation | 9449 Balboa Avenue, Suite 210 San Diego, CA 92123
P: 858.277.5300 F. 858.427.6700 www.dalrada.com

INJURED EMPLOYEE
TEMPORARY MODIFIED WORK OFFER
Production/Warehouse/Maintenance Yard Helper

DATE: _____

EMPLOYEE: _____ SOCIAL SECURITY NUMBER_____

You have been offered a job at _____; starting on _____

working from _____ A.M./P.M. to _____A.M./P.M.

You will sweep, empty trash, sort parts, clean parts and machines. Organize general work area and light housekeeping duties to ensure cleanliness and safety. General production/warehouse/maintenance support as needed and required by supervision.

(Duties will not require repeated or extensive stooping, pulling, pushing, bending, reaching or lifting of objects over 10 pounds.)

While you are still recovering from your injury, Dalrada has made all provisions for temporary modified work. It has been determined that the above position will fit all limitations established by your treating physician during the recuperative period. If at any time you are asked to perform a task that does not fall within your restrictions, **call Dalrada immediately** for further instructions.

It is also required of you to call in when not planning on appearing for work. If you fail to call in and do not show up for work, it will be considered a voluntary quit and you will not be eligible for re-employment with The Solvis Group unless your treating physician concurrently determines and notifies us, by the end of the business day, that you cannot do the temporary modified work.

The Modified-Duty assignment is temporary. Our goal is to return you to your regular work assignment as soon as the doctor removes or reduces your physical limitations.

Management may designate work schedules and location. No overtime is allowed for modified duty positions. Employee is only paid for the hours worked.

Note: Modified duty positions fall under the same standards of work practices, policies and procedures as any other *(Client Company)* / Dalrada positions.

Nothing in this is document constitutes a guarantee of the continued employment or alters Dalrada policy of at-will employment, by which you or Dalrada may terminate employment at any time with or without cause.

Please sign below that you understand and agree with the above statements.

_____ _____
Employee Signature Date

_____
Employee Print Name

_____ _____
Dalrada Financial Representative Date
Copy: Employee

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REFUSAL TO FILE A WORKERS' COMP. CLAIM

PLEASE READ CAREFULLY BEFORE SIGNING

I, _____ have elected not to obtain any medical treatment for my injury dated _____. My decision for not pursuing a workers compensation claim is solely my decision. I am of sound of mind and have not been pressured, forced, coerced, or promised anything in return for my withdrawal of this claim. I further understand that I have one year from the date of injury to pursue a claim.

I declare under penalty of perjury, according to the laws of the State of California, that the foregoing is true and correct.

_____
Date

_____
Signature

_____
Print Signature

_____
Dalrada Financial Representative