American Claims Management
P.O. Box 85251
San Diego, CA 92186-5251

Innovative Solutions.
Exceptional Results.

Dear Policyholder,

You have purchased Workers' Compensation Insurance through Arrowhead General Insurance Agency. Your carrier has partnered with American Claims Management (ACM), a subsidiary of Arrowhead General Agency, to provide you with workers' compensation claims services. It is our goal to make your transition to ACM as smooth and seamless as possible and to provide claim services that are in-sync with the intricacies of your business. Attached please find your introductory claims kit. This package includes directions on how to file a claim in the event that an injury occurs, as well as information regarding different types of exposures or injuries.

For your convenience, all forms are available online at our website, www.ACMClaims.com. On ACM's home page, navigate to the Policy Holder tab on the right hand side of the screen. Select Workers' Compensation as the Line of Business and you will then be directed to the Workers' Compensation site. Select Forms. There the Policy Holder Kit and other useful forms such as the Employer's Report of Injury Form ICA 04-0101 will be available to save or print.

ACM will work together with you to make sure that you have all the information you need to communicate this change to your employees. Let me know if you have any questions or need any further information.

We look forward to helping you manage your workers' compensation program.

Regards,

American Claims Management Inc.

American Claims Management
P.O. Box 85251
San Diego, CA 92186-5251

Helpful Contact Information

How to Report a Claim:
Via Phone - #866-671-5042
Via Fax - #619-744-5030
Via Email - Reportaclaim@acmclaims.com
Via Internet - www.acmclaims.com

How to Request a Claims Kit:
Email - wcinfo@acmclaims.com

Additional Inquiries:
Bill Review Help Desk: billreview@acmclaims.com
Loss Run Requests: lrr@arrowheadgrp.com
General Questions: wcinfo@acmclaims.com

ACM's Mailing Address:
PO Box 85251
San Diego, CA 92186

ACM's Contact Numbers:
Toll Free Number: 866-671-5042
Fax Number: 619-744-5030

Instructions on State Form Requirements – Arizona

POSTING NOTICE – NOTICE TO EMPLOYEES/AVISO A LOS EMPLEADOS

- This notice is required by law and must be posted in a conspicuous place at all company work sites. It contains information about employee rights if an injury occurs. Use only the approved notice included in your policyholder kit. Failure to properly post it may subject your company to a penalty.

WORKERS' COMPENSATION NOTICE TO EMPLOYEES & WORK EXPOSURE TO BODILY FLUIDS (State Form ICA 04-615-01) (Posting Notice – English & Spanish)

- These notices are required by law and must be posted at all times and displayed in a conspicuous place at each Arizona location of your business where all employees can and will see them. Use only the approved notices included in your policyholder kit.

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS

- You are required by law to provide your employees with this form if exposure to bodily fluids is reported. Document the date you provided the form to the employee, when the completed form is returned, initial and date it and keep it for future reference. If a claim is filed, a copy of this report should be attached to your Employer's Report.

WORK EXPOSURE TO METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA), SPINAL MENINGITIS OR TUBERCULOSIS (TB)

- This notice is required by law and must be posted at all times and displayed in a conspicuous place at each Arizona location of your business where all employees can and will see them. Use only the approved notices included in your policyholder kit.

SIGNIFICANT EXPOSURE UNDER THE ARIZONA WORKERS' COMPENSATION ACT

- This document explains the requirements for a possible significant exposure to Methicillin-Resistant Staphylococcus Aureus (MRSA) and other contagious diseases.

EMPLOYEES NOTICE OF REJECTION TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW (State Form ICA 04-0113)

EMPLOYEES NOTICE TO REVOKE REJECTION TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

- Both of these forms listed above are required by law to be kept available at all times. Any employee has the right to reject the provisions of the workers' compensation act or revoke that rejection prior to being injured. You should not coerce anyone into doing so. Keep a copy for your records and send one copy to us within 5 days of receipt.

Instructions on State Form Requirements – Arizona

EMPLOYER'S REPORT OF INDUSTRIAL INJURY
(State Form ICA 04-0101)

- This form is required when a work related injury or illness occurs or is claimed, and assistance with completion is available at the toll free number for claim reporting.
- Follow instructions on the enclosed "How to Report a Work Related Injury".
- Make sure to keep a copy of the completed report form for your records, and give a copy to the employee.
- All claims for workers' compensation benefits must be reported regardless of merit, to allow for proper processing and investigation.

Failure to comply with all of the above instructions may result in monetary fines being assessed by the State.

The State of Arizona Industrial Commission website is www.ica.state.az.us where further information can also be found.

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

_____

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE

1. LAST NAME | FIRST | M.I.
2. SOCIAL SECURITY NUMBER *
3. BIRTH DATE
4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
5. TELEPHONE
6. SEX ☐ MALE ☐ FEMALE
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME
9. POLICY NUMBER
10. NATURE OF BUSINESS (MANUFACTURING, ETC.)
11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS
14. TIME OF EVENT ☐ A.M. ☐ P.M.
15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M.
16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY
18. DATE OF RETURN TO WORK
19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED
20. CLASS CODE ON PAYROLL REPORT
21. EMPLOYEE'S ASSIGNED DEPARTMENT
22. DEPARTMENT NUMBER
23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED
27. FATAL ☐ YES ☐ NO
28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO
NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO
IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO
37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M.
38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO
39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE
41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $
42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR
44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH
$ PER ☐ ☐ ☐ ☐
45. IS EMPLOYEE FURNISHED VALUE
☐ LODGING ☐ BOARD ☐ BOTH $
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)
47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR
49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $
51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY
53. WAGE BEFORE INCREASE $
54. WAGE AFTER INCREASE $
55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
(Full Name of Employer)

_____
(Address of Employer in Full)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

_____ _____
(Employee Print Name Here) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF
TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
(Full Name of Employer)

_____
(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF REJECTION OF THE TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW SIGNED BY ME ON _____.

_____ _____
(Employee Print Name Here) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.

SIGNIFICANT EXPOSURE UNDER THE ARIZONA WORKERS' COMPENSATION ACT

In 2011, the Arizona Legislature amended the reporting requirements for a possible significant exposure to Methicillin-Resistant *Staphylococcus Aureus* (MRSA), which are found in Arizona Revised Statutes section 23-1043.04(B). Effective July 20, 2011, employees must report a possible significant exposure to MRSA that occurs at work to their employers within thirty calendar days after the possible significant exposure. Employees must also be diagnosed with MRSA within fifteen days after the employee reports the possible significant exposure to their employer(s). Employees should use the *updated form* to report significant exposure. Employers must display the updated *Notice to Employees* (poster) titled "Work Exposure to Methicillin-Resistant *Staphylococcus Aureus*, Spinal Meningitis or Tuberculosis (TB)." Reporting forms and posters, including the exposure reporting form and the Notice to Employees, are available from the Industrial Commission of Arizona's website at http://www.azica.gov.

What is a Significant Exposure Under the Arizona Workers' Compensation Act?

A report of significant work exposure to blood, bodily fluids, or other potentially infectious materials may be made by completing a form that reports this exposure. This form may be obtained from your employer or on the Industrial Commission of Arizona website at http://www.azica.gov. But, what is a "significant exposure"? In some instances, such as an exposure to bloodborne pathogens, you may not know if the blood, bodily fluids or other material to which you are exposed is infectious. In other instances, such as an exposure to Tuberculosis, MRSA, or Meningitis, you may know if the exposure is "significant" based on the symptoms of the person to whom you are exposed. Understanding the pathogens involved and how they are spread will help you answer the question, but if you have any concern as whether you should report the exposure, then you should "play it safe." Talk to your doctor, talk to your HR Department, or simply use this form to report what you believe to be a significant exposure. For more information regarding the requirements for filing a workers' compensation claim for a significant work exposure, and the presumptions that are available to certain classes of employees, please read the posters that are required to be posted at your workplace that contain this information. This information is also available on the Industrial Commission of Arizona website at http://www.azica.gov.

Bloodborne Pathogens

Bloodborne pathogens ("BBP") are disease causing organisms such as human immunodeficiency virus ("HIV"), hepatitis B, or hepatitis C that may be present in human blood or bodily fluids that are considered "other potentially infectious material." "Human Blood" includes human blood components and products made from human blood. "Other potentially infectious material" ("OPIM") includes semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any bodily fluid that is visibly contaminated with blood. Unless visibly contaminated with blood, these pathogens

are not transferred through tears, saliva (except in dental procedures), or perspiration. An easier way to think about this is to remember that OPIM are bodily fluids that are intended to always remain inside the body, sexual fluids, and any human tissue that is intended to be covered by skin. A significant exposure to BBP may occur when you come into contact with blood or OPIM through a break or rupture in your skin (e.g., needlestick injury or you cut yourself with a sharp instrument contaminated with blood), or your mucous membranes (e.g. blood or OPIM gets in your eyes, nose, mouth, or you engage in sexual activity with an infected person). The CDC indicates that a human bite that breaks the skin should also be considered a significant exposure. Additional information on HIV and Hepatitis may be found at www.cdc.gov.

Tuberculosis

Tuberculosis (TB) is a contagious disease that spreads through the air. Only people who are sick with active TB disease in their lungs are infectious. When infectious people cough, sneeze, talk or sing, they propel TB germs, known as droplet nuclei, into the air. These germs can stay in the air for several hours, depending on the environment. While not normally transmitted within minutes or hours of sharing the same "airspace," a person needs only to inhale a small number of the TB germs to be infected. You do not get TB by just touching the clothes or shaking the hands of someone who is infected. Tuberculosis is spread (transmitted) primarily from person to person by breathing infected air during close contact. A person infected with active TB may show general symptoms of unexplained weight loss, loss of appetite, night sweats, fever, fatigue, and chills. Other symptoms of TB of the lungs include coughing for 3 weeks or longer, coughing up blood, and chest pain. Additional information on TB can be found at www.cdc.gov.

MRSA

Methicillin-Resistant Staphylococcus Aureus, also known as MRSA, is a potentially dangerous type of staph bacteria that has become resistant to one family of common antibiotics. MRSA is a contact risk. You can get MRSA through direct contact with an infected person, sharing personal items (such as towels or razors that have touched infected skin) or touching shared items (clothing, door knobs, workout benches, etc.). Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be red, swollen, painful, warm to the touch, full of pus or other drainage, and accompanied by a fever. Many people describe it as looking like a spider bite. Additional information on MRSA can be found at www.cdc.gov.

Meningitis

Meningitis is a disease caused by the inflammation of the protective membranes covering the brain and spinal cord known as the meninges. The inflammation is usually caused by an infection of the fluid surrounding the brain and spinal cord. Meningitis is also referred to as spinal meningitis. Meningitis may develop in response to a number of causes, but it is usually caused by bacteria or viruses. Bacterial meningitis is spread from person to person through the exchange of respiratory and throat secretions, normally occurring through coughing, kissing, and sneezing. It is not spread through casual contact or by simply breathing the air where a person

with meningitis has been. It is considered a "heavy droplet" contact risk, similar to a cold, but not nearly as contagious as the cold. Viral meningitis is also spread from person to person through respiratory secretions (saliva, sputum, or nasal mucus) of an infected person. It can also be spread from person to person through fecal contamination (which can occur when changing a diaper or using the toilet and not properly washing hands afterwards). An adult infected with meningitis may have a high fever, severe headache, stiff neck, sensitivity to bright light, sleepiness or trouble waking up, nausea, vomiting, or lack of appetite. Bacterial meningitis can be more severe and immediate care can be important. Additional information on meningitis can be found at www.cdc.gov.

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ Birth Date _____ Job Title _____
   Last Name First M.I.
2. Address _____ Phone No. _____
3. Employer's Full Name _____
4. Employer's Address _____
5. Date of Exposure _____ Time of Exposure _____ A.M. _____ P.M. _____
6. Address or Location of Exposure _____
7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific) _____

_____

_____

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.

☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe)_____
☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions ☐ Other (specify):_____
☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ☐ Unknown ☐ Known
Name _____ DOB _____ Phone No. _____
Address _____ City _____ State _____ Zip _____

10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)? _____

_____

11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)? _____

_____

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**