

**EMPLOYEE INJURY CHECKLIST**

Report incident to Supervisor ASAP	
Call medical triage if applicable	
Completed incident form	
Complete Claim form	
Attend medical examination	
Provide medical /work status slips to employer	
Communicate with employer	

## Employee's Report of Injury Form

**Instructions:** Employees shall use this form to report all work related injuries, illnesses, or “near miss” events (which could have caused an injury or illness) – *no matter how minor*. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when?	Supervisor:
Your signature:	Date:



**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.

**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 División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

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

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios 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 ocurrió el accidente.* \_\_\_\_\_  
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* \_\_\_\_\_  
7. Social Security Number. *Número de Seguro Social del Empleado.* \_\_\_\_\_  
8.  Check if you agree to receive notices about your claim by email only.  Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico. Employee's e-mail. \_\_\_\_\_ Correo electrónico del empleado. \_\_\_\_\_  
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*  
9. Signature of employee. *Firma del empleado.* \_\_\_\_\_

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

10. Name of employer. *Nombre del empleador.* \_\_\_\_\_  
11. Address. *Dirección.* \_\_\_\_\_  
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_  
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* \_\_\_\_\_  
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* \_\_\_\_\_  
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_  
16. Insurance Policy Number. *El número de la póliza de Seguro.* \_\_\_\_\_  
17. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_  
18. Title. *Título.* \_\_\_\_\_ 19. 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.

**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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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