DISTRICT ACCIDENT/INCIDENT REPORT

DISTRICT NAME: ______________________________

☐ **ACCIDENT INVESTIGATION REPORT** ☐ **EMPLOYEE INCIDENT REPORT**

Site Location:______________________ Date & Time of Injury/Incident______________________

Hours Worked (normal workday):_______ Start: ___________ End:___________

Employee's Department________________ Date Reported______________________

Employee's Name	Social Security Number Date of Birth	
Home Address *(PO Box or Street #, city, state/zip)*	Home Phone Number	Sex: ☐ Male ☐ Female Occupation:
Any Witnesses? ☐ Yes ☐ No If yes, give names below:		
Task being performed when accident/injury occurred:		
Describe the accident/incident and body parts affected:		
Have you injured this part of your body before? ☐ Yes ☐ No If yes, explain below:		

Do you require medical attention now? ☐ Yes ☐ No

If yes, your Supervisor will notify your district office to secure a referral slip to a SIG Medical Network Provider. If medical aid is not required at this time, your Supervisor will retain a copy of the incident report and forward a copy to the district office.

If medical attention is not needed for this incident now but is necessary at a later date, you understand that you **MUST** contact your site supervisor and the District Office Claims Coordinator **PRIOR TO** seeking or obtaining treatment.

Failure to report occupational injuries in a timely manner and/or failure to comply with the District's policies for medical treatment of occupational injuries could result in disciplinary action. It may also result in a delay of any possible Workers' Compensation benefits while the District and the insurance carrier investigate your claim.

Employee Signature:	Date
Supervisor Signature	Date

Supervisor: What preventative action should have been taken by the employee or others to avoid this type of accident? (Include recommendations from the employee.)

What actions have been taken on these recommendations? (Include dates)

Note: Any person who makes or causes to be made, any knowingly false or fraudulent material representation for the purpose of obtaining or denying Workers' Compensation benefits or payments is guilty of a felony.

Send original to Personnel Services, District Office. Keep a copy at site.
If condition presents a safety hazard**, send a copy & work order to Maintenance for repair.**

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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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. ☐ 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 adminstradora de seguros.*
Acclamation Insurance Management Services P.O. Box 269120 Sacramento, CA 95826
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 <u>one working day</u> 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*

ACKNOWLEDGEMENT OF RECEIPT
of
Employee Claim Form

I acknowledge receipt of an Employee's Claim for Workers' Compensation Benefits (Form DWC-1).

This information was received:

From: ______________________________
(Manager, Supervisor or Lead Person)

District Name: ______________________________

On: ____________________ At: ____________________
(Date) (Time)

______________________ ______________________
Employer Signature Employee Signature

______________________ ______________________
Date Date

Note: If you need treatment for this incident later, bring your copy of the DWC-1 to the District Office representative and to your Supervisor or Principal. The District Office will authorize an Urgent Care visit to the SIG-Designated Occupational Health Clinic most convenient to you.