

STATE OF CALIFORNIA

**ACKNOWLEDGMENT OF RECEIPT  
OF THE DWC-1**

**TO: Departmental Employee**

**SUBJECT: Acknowledgement of Receipt of the DWC-1, Workers' Compensation  
Claim Form & Notice of Potential Eligibility**

Attached is a *Workers' Compensation Claim Form & Notice of Potential Eligibility* (DWC-1). Your supervisor or manager is required to provide this form to you upon receiving notification of a work-related injury or illness.

When you receive the DWC-1, complete this form and return it to your supervisor or manager.

You must complete the DWC-1 if you want to pursue a claim for a work-related injury or illness. The District is self insured. Therefore, BUSD uses a Third Party Administrator who is responsible for making all liability determinations regarding your claim. JT2 Integrated Resources (Third Party Administrator) determines liability using available medical documentation and relevant facts.

**Supervisor's Section:** The supervisor must complete this section. Enter the date the DWC-1 was sent to the employee by certified mail.

When the employee returns this form, forward it to the Office of Risk Management, Attention: Workers Compensation Specialist at: 2134 Martin Luther King, Jr. Way, Berkeley, CA 94704.

**EMPLOYEE'S ACKNOWLEDGMENT OF RECEIPT**

This is to acknowledge that I have received a DWC-1, *Workers' Compensation Claim Form & Notice of Potential Eligibility*.

I understand that if I want to pursue a claim for a work-related injury or illness, it is my responsibility to complete the DWC-1 and return it to my supervisor.

EMPLOYEE NAME	DATE OF INJURY OR ILLNESS
DATE DWC-1 RECEIVED	EMPLOYEE SIGNATURE ►

**SUPERVISORS SECTION**

DATE DWC-1 SENT "CERTIFIED MAIL"	SUPERVISOR'S SIGNATURE ►
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# Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

## Formulario de Reclamo de Compensación de 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. 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 pre-designated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. 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 you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to \$10,000 in treatment until the claim is accepted or rejected.

**Disclosure of Medical Records:** After you make a claim for workers' compensation benefits, your medical records will not have the same level of 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, for most injuries you will receive temporary disability payments for a limited period of time. 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.

**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

Si Ud. se lesiona o se enferma, ya sea físicamente 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 de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de 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 administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene 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 administrador de reclamos. Los beneficios no pueden comenzar hasta que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

**Atención Médica:** Su administrador 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 de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

**El Médico Primario que le Atiende-Primary Treating Physician PTP** es el médico con la responsabilidad total para tratar 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 o grupo médico previamente 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 diferentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por \$10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

**Divulgación de Expedientes Médicos:** Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el 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 para la mayoría de las lesiones por un período limitado. 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 impuestos. Los pagos

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

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



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.

**Supplemental Job Displacement Benefit (SJDB):** If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning 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.

**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 (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at [www.dwc.ca.gov](http://www.dwc.ca.gov).

**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](http://www.californiaspecialist.org).

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 una 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 administrador 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 ser temporal o podría extenderse 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.

**Beneficio Suplementario por Desplazamiento de Trabajo:** Si Ud. se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna 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 requisitos, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

**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 viven en el hogar y que dependían económicamente del trabajador difunto.

**Es ilegal que su empleador** le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Código Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del 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 de Trabajadores (*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 consultar con la página Web de la DWC en [www.dwc.ca.gov](http://www.dwc.ca.gov).

**Ud. puede consultar con un abogado.** La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California (*State Bar*) al (415) 538-2120, ó consulte con la página Web en [www.californiaspecialist.org](http://www.californiaspecialist.org).



**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 oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

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 donde 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. 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.* Berkeley Unified School District
- 10. Address. *Dirección.* 2134 Martin Luther King Jr. Way, Berkeley, CA 94704-1180
- 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 administradora de seguros.*  
JT2 Integrated Resources: P.O. Box 8021, Pleasanton, CA 94588
- 15. Insurance Policy Number. *El número de la póliza de Seguro.* "Self-insured"
- 16. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
- 17. Title. *Título.* \_\_\_\_\_ 18. Telephone. *Teléfono.* \_\_\_\_\_

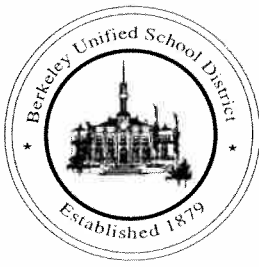
**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

**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



# WITNESS STATEMENT

[Form RM-04]

Rev. 12/2009

The **statement** of a(n):

- STUDENT
- EMPLOYEE
- VOLUNTEER
- VISITOR
- Other:

<b>WITNESS INFO</b>	NAME:	DRIVERS LICENSE NUMBER:	D/L ISSUING STATE:
	STREET NUMBER:		WORK PHONE:
	CITY, STATE and ZIP:		HOME PHONE:

**LOCATION** of INCIDENT (i.e. address, particular part of the building, etc. – include as much detail as possible)

WHERE WERE **YOU** in RELATION to the INCIDENT WHEN it OCCURRED?

DATE:	TIME: AM / PM	<b>WAS ANYONE INJURED</b> in THIS INCIDENT?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
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NAME of <b>INJURED PARTY</b> : (if applicable)	<b>TYPE of INURY</b> IF KNOWN:
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DO YOU PERSONALLY <b>KNOW</b> the <b>INJURED</b> or any <b>INVOLVED PARTIES</b> ? <input type="checkbox"/> YES <input type="checkbox"/>	NAME of <b>KNOWN PARTY</b> (if appl.):	<b>RELATIONSHIP</b> (if appl.):
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DESCRIBE **HOW** the **INCIDENT OCCURRED** (include complete names of parties involved and make sketches, if appropriate):

**SKETCH ON BACK**

DESCRIBE ANY APPARENT **DAMAGE** to **PROPERTY**

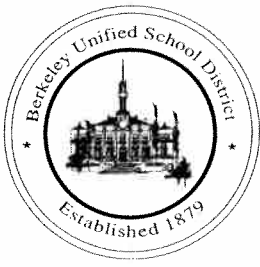
IN YOUR OPINION WHAT WERE the **ROOT CAUSES** of the INCIDENT:

DISTRICT **EMPLOYEE MOST FAMILIAR** WITH THIS INCIDENT:

EMPLOYEE CONTACT **PHONE**:

**FAX or E-MAIL a COPY of this completed form to **RISK MANAGEMENT** at: (510) 877-8348**  
**FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS.**

<b>WITNESS</b> NAME:	<b>WITNESS</b> SIGNATURE:	<b>DATE:</b>
<b>INTERVIEWER's</b> NAME (if. appl.):	<b>INTERVIEWER's</b> SIGNATURE:	<b>DATE:</b>



# SUPERVISOR'S REPORT

[Form RM-05]

Rev. 06/2011

The statement of a(n):

- DIRECTOR
- MANAGER
- SUPERVISOR
- LEAD/ COORDINATOR.
- Other:

EMPLOYEE'S INFO	EMPLOYEE'S NAME:		JOB TITLE:	SOCIAL SECURITY NO:
	HOME ADDRESS:			WORK PHONE:
	CITY, STATE and ZIP:			HOME PHONE:
	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH:	EMPLOYMENT STATUS: <input type="checkbox"/> Perm/Full Time <input type="checkbox"/> Perm/ Part-time <input type="checkbox"/> Substitute <input type="checkbox"/> 9 mo <input type="checkbox"/> 10 mo <input type="checkbox"/> 11 mo <input type="checkbox"/> 12 mo <input type="checkbox"/> Other: _____	

<b>LOCATION</b> of INCIDENT (i.e. address, particular part of the building, etc. – include as much detail as possible)		
WHERE WERE <b>YOU</b> in RELATION to the INCIDENT WHEN it OCCURRED?		
DATE YOU WERE NOTIFIED:	TIME:  AM / PM	WAS ANYONE ELSE INJURED in THIS INCIDENT?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
NAME of OTHER INJURED PARTY: (if applicable)		TYPE of INJURY/ILLNESS IF KNOWN:
Was there any <b>PROPERTY DAMAGE</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the employee need to seek medical treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was employee referred to <b>CompanyNurse</b> (if applicable.):

DESCRIBE **HOW** the INCIDENT OCCURRED (include complete names of parties involved and make sketches, if appropriate):

SKETCH ON BACK

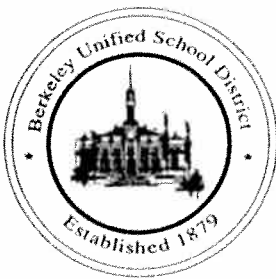
DESCRIBE ANY APPARENT **DAMAGE** to **PROPERTY** (What was damaged and describe damage, i.e., : truck bumper, dented; car windshield, cracked)

IN YOUR OPINION WHAT WERE the **ROOT CAUSES** of the INCIDENT:

Has employee missed any time from work? Yes <input type="checkbox"/> No <input type="checkbox"/> What was last day of work: ___/___/___	Have you provided a claim form to the employee with a work comp packet?: Yes <input type="checkbox"/> No <input type="checkbox"/> When was form provided: ___/___/___
Has employee returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> When did they return to work: ___/___/___	

**This form must be completed immediately upon knowledge of an accident and submitted to Risk Management at: (510) 877-8348 or e-mail to: risk@berkeley.k12.ca.us. FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS. Thank you.**

SUPERVISOR'S NAME:	SUPERVISOR'S SIGNATURE:	DATE:
JOB TITLE:	WORK LOCATION:	WORK PHONE:



# REPORT of INCIDENT

[Form RM-03]

Rev. 7/2010

This report is for a(n):

- ACCIDENT
- INJURY
- ILLNESS
- Report Only

[check all that apply]

The affected party is a(n):

- STUDENT
- EMPLOYEE
- VOLUNTEER
- VISITOR
- Other:

LOCATION CODE:

INCIDENT NUMBER:

CLAIM NUMBER (if appl):

OFFICE USE ONLY

AFFECTED PARTY	FULL NAME:	JOB TITLE (if applicable):
	HOME ADDRESS:	WORK PHONE:
	CITY, STATE and ZIP:	HOME PHONE:

INCIDENT ADDRESS:	DATE of INCIDENT:
CITY, STATE and ZIP:	TIME of INCIDENT <span style="float: right;">AM / PM</span>

DESCRIBE the ACTIVITY OCCURRING JUST PRIOR to the INCIDENT:

[#1] CONTINUED on BACK

DESCRIBE HOW the INCIDENT OCCURRED:

[#2] CONTINUED on BACK

OBJECT, EQUIPMENT or CHEMICAL THAT DIRECTLY CAUSED HARM:

MANAGER or SUPERVISOR IN CHARGE at TIME of INCIDENT:	CONTACT PHONE:
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WITNESS NAME (if applicable):	WITNESS PHONE:
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WITNESS NAME (if applicable):	WITNESS PHONE:
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DESCRIBE any INJURY or ILLNESS (DIAGNOSIS):

SOUGHT TREATMENT? <small>Yes / No</small>	TREATED in an EMERGENCY ROOM? <small>Yes / No</small>	HOSPITALIZED OVERNIGHT as an INPATIENT? <small>Yes / No</small>	DATE of DEATH (if applicable):
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HOSPITAL or CLINIC NAME and CITY:	PHYSICIAN NAME:
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FIRST AID GIVEN at the SCENE:	PHYSICIAN PHONE:
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SCHEDULED WORK HOURS	From: <span style="float: right;">To:</span>	AM / PM <span style="float: right;">AM / PM</span>	LOST TIME from WORK? <small>Yes / No</small>	DATES MISSED	From: <span style="float: right;">To:</span>
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**SIGNING THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.**

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality employees to the fullest extent possible while the information is being used for occupational safety and health purposes. See e.g. 5 C.C.R. § 14300.29(b)(6)-(10).

Within 7 days of knowledge that a "recordable" injury or illness has occurred, supervisors must ensure that this form, or the Cal/OSHA Form 301, are completed.

**FAX or E-MAIL a COPY of this completed form to RISK MANAGEMENT at: (510) 877-8348**

**FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS.**

NAME and TITLE of REPORTING PARTY:	SIGNATURE:	DATE:
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01/14/2018 New Fax Number 707 826-1110