Carmel Unified School District

WORKER'S COMPENSATION

INCIDENT ONLY REPORT

Please have all parties complete and return as soon as possible to:

Geri Simmons
Worker's Compensation Coordinator
District Office - Human Resources Dept.

Thank you!
INDUSTRIAL INJURY MEDICAL SERVICE ORDER

To Physician: __________________________________________

Address: __________________________________________

Please render medical treatment to the following employee in accordance with the terms of the Workers’ Compensation Laws. Complete and fax or email timely a Doctor’s first Report of Occupational Injury and Illness to the fax number or email address below.

Full name of Employee: ______________________________________

Site: __________________________ Occupation: __________________________

Date of Injury: ___________ Time of Injury: ___________

Authorized by:

Sign: __________________________ Print: __________________________

Date: __________________________ Title: __________________________

DECLINATION STATEMENT

I have declined the offer of medical treatment for the injury as follows:

Date of Injury: ___________ Time of Injury: ___________

How the incident occurred:

________________________________________________________

________________________________________________________

Part of Body Affected: __________________________ Occupation: __________________________

Reason for Declination:

________________________________________________________

Print Full Name: __________________________

Signature: __________________________ Date: __________________________

Monterey Educational Risk Management Authority
P.O. Box 3320 Salinas, CA 93912
Phone (831) 783-3311 Fax (831) 783-3333

Rev 06-2012
Instructions for completing Form DWC-1
Employee Claim for Workers' Compensation Benefits

State law requires that the Employee's Claim for Workers' Compensation Benefits form (DWC-1 Form) be given to the employee within one working day of notice of injury. This does not include minor injuries such as first-aid unless the employee requests the form. State law does not require the employee to complete the form. It is the employee's right to choose not to do so. The employee uses it to request workers' compensation benefits. They should complete and sign the employee portion of the claim form. They need to describe the injury/illness and include every part of the body affected. Returning the form is called filing the claim form (this notifies the employer that the employee is pursuing workers' compensation benefits).

STEP ONE: Issue injured employee DWC-1 form within one working day. They must complete the Employee Section and return it to their employer for claim to be processed.

Employee Section: PLEASE PRINT CLEARLY.
Line 1: Enter employee's full name. Enter today's date.
Line 2: Enter employee's home address
Line 3: Enter employee's city, state, and Zip Code.
Line 4: Enter date and time of injury.
Line 5: Enter address and description where injury occurred
Line 6: Enter description of the injury and the part of the body affected.
Line 7: Enter employee's social security number.
Line 8: Employee's signature.

STEP TWO: When employee returns the DWC-1 form, employer must finish the Employer Section and send form for processing.

Employer Section: PLEASE PRINT CLEARLY.
Line 9: Enter name of employer.
Line 10: Enter full address of the employer.
Line 11: Enter the date the employer first knew of the injury.
Line 12: Enter the date the claim was provided to the employee.
Line 13: Enter the date the employer received the completed claim form
Line 14: Enter the name of the insurance carrier or the adjusting agency, if applicable.
Line 15: Enter the policy number of the insurance.
Line 16: Employer's signature.
Line 17: Enter the title of the employer representative completing the claim form.
Line 18: Enter the telephone number of the representative completing the claim form.

STEP THREE: Fax a copy into the office below, as soon as possible, and mail the YELLOW COPY in for immediate processing. Please mail to:

Geri Simmons
Worker's Compensation Coordinator
Carmel Unified School District Office
Human Resources Department
Phone: 624-1546 x 2016
Fax: 626-4052
WORKERS' COMPENSATION CLAIM FORM (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.

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.

Employee—complete this section and see note above

1. Name. ____________________________
2. Home Address. Dirección Residencial. ____________________________
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. 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.

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 empleador 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. ____________________________

Insurance Policy Number. El número de la póliza de Seguro. ____________________________

Signature of employer representative. Firma del representante del empleador. ____________________________

Title. Título. ____________________________ Telephone. Teléfono. __________

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

☐ Employer copy/Copia del Empleado
☐ Employee copy/Copia del Empleado

☐ Claims Administrator/Administrador de Reclamos
☐ Temporary Receipt/Recibo del Empleado

5/10 Rev.

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

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 está 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.

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

Empleado: Se requiere que Ud. feche esta forma y que provéa copias a su compañia de seguros, administrador de reclamos, o dependient/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 ADMISSION DE RESPONSABILIDAD

☐ Claims Administrator/Administrador de Reclamos
☐ Temporary Receipt/Recibo del Empleado
### Nature of Injury:

| ☐ ABRASION | ☐ FOREIGN BODY |
| ☐ AMPUTATION | ☐ FRACTURE |
| ☐ BITE/STING | ☐ HEAT STRESS |
| ☐ BURN – CHEMICAL | ☐ HERNIA |
| ☐ BURN – CONTACT | ☐ INFECTION |
| ☐ BURN – ELECTRICAL | ☐ LACERSATION |
| ☐ BURN – FLAME | ☐ MULTIPLE INJURY |
| ☐ BURN – FLASH | ☐ PAIN |
| ☐ CONTUSION | ☐ PUNCTURE |
| ☐ CRUSH | ☐ STRAIN/SPRAIN |
| ☐ DISLOCATION | ☐ OTHER: EXPLAIN |
| ☐ EXCESSIVE HEAT/COLD | |

### Medical Treatment:

| ☐ SELF-TREATMENT | ☐ PRE-DESIGNATED PHYSICIAN |
| ☐ 911 | ☐ OCCUPATIONAL MEDICAL CLINIC |
| ☐ URGENT CARE | ☐ OTHER |
| ☐ EMERGENCY ROOM | |

### Safety Rules Established:

| ☐ Yes | ☐ No |
| ☐ NOT ENFORCED | |

### Witnesses:

| ☐ Yes | ☐ No |

### Names (Please use witness statement):

1. 
2. 
3. 
4. 
5. 

### Supervisor:

**DO YOU HAVE ADDITIONAL INFORMATION ON THIS ACCIDENT?**

☐ Yes. If so, please use the Supervisor's investigation form.

☐ No

**Please complete the Supervisor's Safety Review.**
## Supervisor's Safety Review

<table>
<thead>
<tr>
<th>Job Task – Check Category and Type</th>
<th>Unsafe Act – Check Category and Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ascending/Descending:</td>
<td>□ Bypassed:</td>
</tr>
<tr>
<td>□ Stairs</td>
<td>□ Guard/Barrier</td>
</tr>
<tr>
<td>□ Vehicle</td>
<td>□ Safety Device</td>
</tr>
<tr>
<td>□ Ladder</td>
<td>□ Disregard:</td>
</tr>
<tr>
<td>□ Equipment</td>
<td>□ Instructions</td>
</tr>
<tr>
<td>□ Banding:</td>
<td>□ Rules</td>
</tr>
<tr>
<td>□ Installing</td>
<td>□ Excessive Speed</td>
</tr>
<tr>
<td>□ Removing</td>
<td>□ Failure:</td>
</tr>
<tr>
<td>□ Clean Up – General</td>
<td>□ Lockout/Tagout</td>
</tr>
<tr>
<td>□ Equipment:</td>
<td>□ Secure</td>
</tr>
<tr>
<td>□ Adjusting</td>
<td>□ Warn</td>
</tr>
<tr>
<td>□ Clearing</td>
<td>□ Obtain/Assistance</td>
</tr>
<tr>
<td>□ Operating</td>
<td>□ Use PPE</td>
</tr>
<tr>
<td>□ Repairing</td>
<td>□ Horseplay/Distraction</td>
</tr>
<tr>
<td>□ Other</td>
<td>□ Incorrect Method</td>
</tr>
<tr>
<td>□ Forklift</td>
<td>□ Impairment – Physical</td>
</tr>
<tr>
<td>□ Material Handling:</td>
<td>□ Improper:</td>
</tr>
<tr>
<td>□ Pushing</td>
<td>□ Lifting</td>
</tr>
<tr>
<td>□ Pulling</td>
<td>□ Loading</td>
</tr>
<tr>
<td>□ Lifting</td>
<td>□ Placement</td>
</tr>
<tr>
<td>□ Powered</td>
<td>□ Inattention to Surroundings</td>
</tr>
<tr>
<td>□ Maintenance:</td>
<td>□ Operating:</td>
</tr>
<tr>
<td>□ Electrical</td>
<td>□ Without Authorization</td>
</tr>
<tr>
<td>□ Fueling</td>
<td>□ Equipment Un Safely</td>
</tr>
<tr>
<td>□ Mechanical</td>
<td>□ Riding Hazardous Equipment</td>
</tr>
<tr>
<td>□ Cleaning</td>
<td>□ Servicing Equipment in Operation</td>
</tr>
<tr>
<td>□ Other</td>
<td>□ Tried to:</td>
</tr>
<tr>
<td>□ Pallet Jack</td>
<td>□ Avoid discomfort</td>
</tr>
<tr>
<td>□ Truck:</td>
<td>□ Save effort</td>
</tr>
<tr>
<td>□ Loading</td>
<td>□ Save Time</td>
</tr>
<tr>
<td>□ Unloading</td>
<td>□ Unsafe:</td>
</tr>
<tr>
<td>□ Supervisory Task</td>
<td>□ Position</td>
</tr>
<tr>
<td>□ Tools</td>
<td>□ Riding</td>
</tr>
<tr>
<td>□ Hand</td>
<td>□ Using defective tools/equipment</td>
</tr>
<tr>
<td>□ Powered</td>
<td></td>
</tr>
<tr>
<td>□ Walking Through Area</td>
<td></td>
</tr>
<tr>
<td>□ Other – Explain below:</td>
<td></td>
</tr>
</tbody>
</table>
UNSAFE CONDITIONS – Check all applicable category and type:

- Congestion
- Clothing – Hazardous
- Control(s)
  - Improper
  - Defective
  - Missing
- Design limitation
- Environment
  - Cold
  - Poor Lighting
  - Gasses/Fumes/Etc
  - Noise
- Equipment:
  - Exposed/Energized
  - Operation
- Fire/Explosion/Hazard
- Handrails:
  - Inadequate
  - Missing
  - Not Installed
- Housekeeping – Poor
- Material - Defective

- PPE:
  - Inadequate
  - Improper
- Sharp Object/Surface
- Storage – Improper/Inadequate
- Substance – Hazardous
- Surface:
  - Slipping Hazard
  - Tripping Hazard
- Tool:
  - Defective
  - Not Available
  - Other
- Training:
  - Inadequate
  - Not given
- Unexpected motion
- Warning system – None/Inadequate
- Windborne Dust
- Other

ADDITIONAL INFORMATION NOT COVERED ABOVE (EXPLAIN BELOW):

ARE THERE OTHER INDIVIDUALS NOT YET CONTACTED WHO MAY HAVE INFORMATION ABOUT THIS INCIDENT?

<table>
<thead>
<tr>
<th>SIGNATURES:</th>
<th>DATE SIGNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPERVISOR:</td>
<td></td>
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<tr>
<td>EMPLOYEE:</td>
<td></td>
</tr>
</tbody>
</table>
**WITNESS STATEMENT**

<table>
<thead>
<tr>
<th>WITNESS NAME</th>
<th>JOB TITLE/POSITION</th>
<th>DATE OF STATEMENT</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>INJURED WORKER</th>
<th>DATE OF INCIDENT</th>
<th>TIME OF INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Give a factual statement of your observation preceding, during and following the occurrence:

<p>| | | | |</p>
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</table>

The above statement is a complete compilation of my understanding of the incident. I understand that this is a confidential statement, which I agree not to share without the expressed permission of this company or by court order.

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Incident Report: Employee Injury or Illness

Carmel Unified School District
(DISTRICT)

SECTION A: To Be Completed By Employee

a. School ___________________________ Department ___________ Accident Date ___________ Hour ___________

b. Employee's Name ___________________________ Soc. Sec. No. (Last 4) ___________________________

c. Occupation ___________________________ Location of Accident (be specific) ___________________________

d. To whom reported and title ___________________________ Date Reported ___________ Hour ___________

e. Description of Accident (include task being performed; step by step detail of incident, and tool, or object involved) ___________________________

 Regular work when injured: Yes [ ] No [ ]

f. Specific body part injured ___________________________ Name(s) of witness(s) ___________________________

[ ] Employee's Signature ___________________________ Home Phone ___________________________ Date ___________

SECTION B: To Be Completed By Supervisor

. What has been or will be done to prevent future similar injuries? ___________________________

. Does the employee have any input on how this type of injury can be avoided in the future? ___________________________

. Any inservice/training necessary for staff: Yes [ ] No [ ] If so, when will this be done? ___________________________

. Any physical deficiencies need correcting: Yes [ ] No [ ] If so, what steps have been taken: ___________________________

. Any procedural/operational changes necessary? ___________________________

Check Medical Aid given:

First Aid? [ ] Describe: ___________________________

Visit Doctor? [ ] Name/Location ___________________________

Hospital? [ ] Name/Location ___________________________

'more than first aid given, be sure to fill out Form 5020 - Employer's Report of Occupational Injury or Illness.

Supervisor's Signature: ___________________________ Phone #: ___________________________ Date: ___________________________

TRIBUTION: Original - Merma Office Copy - District Office Copy - Personnel File

Reference: Car Title &: S.3235 Revised: May 2012