COVERSHEET CHECKLIST

EMPLOYEE: _____

COMPANY NURSE CONTACTED AT 1-877-518-6702

___ *COMPANY NURSE REPORT #*_____

___ *EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS*

___ *EMPLOYEE SIGNS INSTRUCTIONS FOR INJURED EMPLOYEE*

___ *EMPLOYEE INJURY DRAWING*

___ *CLASSIFIED EMPLOYEES SIGN 1/3 SICK/VACATION USE REQUEST*

___ *EMPLOYEE COMPLETES FAMILY CARE LEAVE REQUEST (FMLA) 12 WEEKS JOB PROTECTION*

___ *TURN IN ANY DISTRICT EQUIPMENT, KEYS, RADIOS, ETC.*

___ ***SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS***

___ *MY MATRIXX W/C PRESCRIPTION INFORMATION CARD*

___ ***WORKERS COMPENSATION CLAIM FORM (DWC-1)***

DECLINATION OF MEDICAL TREATMENT ALONG WITH DWC-1

WITNESS STATEMENT IF APPLICABLE

Employee Signature received-complete w/c package including FMLA request, Classified vacation/sick request

_____ _____

Employee Signature *Date*