Mt. Diablo Unified School District

1936 Carlotta Drive • Concord, CA 94519

EMPLOYEE REPORT OF INJURY OR ILLNESS

To be completed for all occupational injuries or illnesses.
(Please print – Use separate sheet of paper if additional room is necessary.)

1. Employee Name	2. Job Title	3. Today's Date _____/_______/______
4. Location where injury happened (site and location)	5. Date of Injury _____/_______/______	6. Time of Injury ____:____ ☐ a.m. ☐ p.m.
7. What part of body was injured? (Be specific)		8. Scheduled Work Hours

9. ☐ Report of Incident only - By checking this box, I understand that I am **NOT FILING** a Workers' Compensation claim at this time. If, in the future, I decide to file a Workers' Compensation Claim, I will immediately inform my Supervisor, and will follow the requirements provided to me for reporting a claim**.** **If you check this box please skip question #10 and move on to #11**. I understand I have one (1) year to file a claim from the date of injury.

10. This claim will be for: ☐ Time loss ☐ Medical Treatment
A copy of the State of California Workers' Compensation Claim Form (DWC-1) was provided to me and must be completed along with this form.

11. Is this an original injury or re-injury? ☐ Original injury ☐ Re-injury	12. If re-injury, was this a work incurred injury with MDUSD? ☐ Yes ☐ No

13. If re-injury, when and where was previous injury?

14. Please describe exactly what happened for this injury.

15. What were you doing/thinking about when accident happened?

16. Did anyone witness the accident? ☐ Yes (If yes, please give names of all witnesses) ☐ No

17. What could you have done to prevent this injury?

18. What could the district have done to prevent this injury?

19. Date you sought medical attention	20. Health Care Provider's Name	21. Telephone number

22. Did you go to?
☐ District Occupational Medicine Office ☐ Your own doctor's Office ☐ Hospital ☐ Emergency Room

Employee signature	**Date**
Employee Home Phone Number and best time to call:	Employee Cell Phone Number and best time to call:

This form must be returned to your Manager or Supervisor as soon as possible to prevent delay of any possible benefits.

Any person who makes or causes to be made any fraudulent statement for the purpose of obtaining or denying workers' compensation benefits is guilty of a felony

Date Supervisor or Manager received report:	Received by:

 Fax and send original to Workers' Compensation 925-680-2505 • 1 copy to be given to employee • 1 copy to be retained at site