



Oxnard School District

WORKERS' COMPENSATION
EMPLOYEE ACKNOWLEDGEMENT FORM

I, _____, received the following forms and information relating to my
Print Employee Name

work-related injury/illness of _____.

Date of Injury

- Company Nurse Information
DWC-1 Claim Form
Body Injury Diagram (English/Spanish)
Employee Statement
Facts About Workers' Compensation Brochure
Workers' Compensation Reporting Procedure
Workers' Compensation Timesheet & Frontline Procedure
Frequently Asked Questions
Ventura County Schools Medical Provider Network
myMatrixx Temporary Prescription ID Card
Notice for use of Vacation in Lieu of Sick (CSEA only)

I understand that for job-related injuries/illnesses, I must receive quality care from a medical provider in the
Initial Ventura County Schools Medical Provider Network unless I pre-designated prior to this injury/illness.

I understand that my employer may accommodate temporary work restrictions in most cases, by offering a
Initial temporary bridge assignment. I understand that if I choose to decline modified work or bridge assignment offered,
I will be required to use sick leave entitlement.

I understand that under certain circumstances my workers' compensation injury MAY be considered a serious
Initial health condition under the Family and Medical Leave Act and that I may be entitled to FMLA/CFRA leave. For
more information I should contact Human Resources Leaves.

I understand that my Workers' Compensation claim may be placed in a delayed status by Athens Administrator.
Initial During this time, if I am placed off work by approved treating physician I will not be entitled to use the sixty (60)
days of Industrial Leave until a decision is made on the compensability of the claim. I will be using my sick leave
entitlement until a decision is reached by Athens Administrators.

I understand that it is my responsibility to read the Workers' Compensation Reporting Procedure, Workers'
Initial Compensation Timesheet & Frontline Procedure and Frequently Asked Questions. I understand that it is my
responsibility to ask questions, if I do not understand any portion of the procedure.

I have received Notification for Use of Vacation in Lieu of Sick (CSEA ONLY)
Initial

I hereby certify that I received the above information and handouts, and it is my responsibility to review these documents
to ensure I have a full understanding.

Employee Signature Date EMP ID #

PLEASE SUBMIT FORMS TO: wcinjury@oxnardsd.org