



**EMPLOYEE'S REPORT  
OF OCCUPATIONAL INJURY OR ILLNESS**

Please complete and return this form to your supervisor IMMEDIATELY. Contact Risk Management (310) 886-1600 ext. 8048 if you have questions.

**PLEASE PRINT CLEARLY**

DATE OF INJURY	TIME OF INJURY	TIME YOU BEGAN WORK
SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED:		
ADDRESS WHERE INJURY OCCURRED:		
BODY PART(S) INJURED IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO       WHEN?          WHERE?		
EQUIPMENT, MATERIALS AND/OR CHEMICALS YOU WERE USING WHEN EVENT OR EXPOSURE OCCURRED:		
SPECIFIC ACTIVITY YOU WERE PERFORMING WHEN EVENT OR EXPOSURE OCCURRED (EXPLAIN SEQUENCE OR EVENTS IN DETAIL):		
DESCRIBE SEQUENCE OF EVENTS LEADING TO INJURY:		
LIST NAMES, ADDRESS, AND PHONES NUMBERS OF PERSONS PRESENT AT TIME OF ACCIDENT:		
NAME:	ADDRESS:	PHONE:
NAME:	ADDRESS:	PHONE:
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
SOCIAL SECURITY NO:		DATE OF BIRTH:
HOME ADDRESS:	CITY:	ZIP CODE:
HOME PHONE:	JOB TITLE:	
DATE OF HIRE:	WORK SCHEDULE (HOURS PER DAY): M ___ T ___ W ___ T ___ F ___ Sat ___ Sun ___	
<p><b>Your signature below signifies your receipt of the following pamphlets:</b></p> <ol style="list-style-type: none"> <li>1. "The Facts About Workers' Compensation"</li> <li>2. Temporary Receipt of "Workers' Compensation Claim Form (DWC-1) &amp; Notice of Potential Eligibility"</li> </ol>		
SIGNATURE:		DATE: