CITY OF PETALUMA
Workers' Compensation Program
INITIAL INJURY PACKET

EMPLOYEE AND SUPERVISOR INCIDENT REPORT

TYPE OF INCIDENT: ☐ First Aid ☐ Minor Injury ☐ Lost Time Injury ☐ Cumulative Trauma
☐ Property Damage/Loss ☐ Vehicle Accident
☐ Biological Exposure ________________ ☐ Chemical Exposure _________________

FULL NAME:	JOB TITLE:	
HOME ADDRESS:	DEPARTMENT/DIVISION:	
	HOURS WORKED DAILY:	
CELL PHONE:	HOURS WORKED DAILY/ WEEKLY:	DAYS WORKED WEEKLY:
EMAIL ADDRESS THAT YOU CHECK REGULARLY:		

INCIDENT DATE:	TIME OF INCIDENT:	LOCATION OF INCIDENT (address):
DATE REPORTED:	TIME BEGAN WORK:	DID YOU RECEIVE FIRST AID OR TREATMENT? IF YES, FROM WHOM:
DID YOU LOSE TIME FROM WORK?	IF YES, WHEN WAS YOUR LAST DAY?	DATE RETURNED TO WORK? IF STILL OFF WORK, CHECK THIS BOX:
NATURE OF INJURY AND BODY PART INJURED:		
EQUIPMENT BEING USED:		
DESCRIBE IN YOUR OWN WORDS HOW THE INCIDENT OCCURRED (sequence of events):		
NAMES OF WITNESS(ES) TO INCIDENT?		
DESCRIBE THE PROPERTY DAMAGE/LOSS, IF ANY:		
WAS THERE AN UNSAFE CONDITION OR ACT THAT CAUSED OR CONTRIBUTED TO THIS INCIDENT? ☐**YES** ☐**NO**, IF "YES" DESCRIBE:		
DO YOU THINK SOMETHING COULD BE DONE TO PREVENT A SIMILAR INCIDENT IN THE FUTURE?		

Please check whether you ARE or ARE NOT currently presenting a Claim:

☐ **I AM PRESENTLY CLAIMING MY MEDICAL CONDITION OR INJURY AS A WORKERS' COMPENSATION (WC) CLAIM AND:**
- ☐ I need a DWC-1 WC Claim Form.
- ☐ I have been given a DWC-1 WC Claim Form and (check one):
  - ☐ I have completed it – to be submitted with Incident Reports.
  - ☐ I will complete it and submit it within 24 hours.

☐ **I AM NOT PRESENTLY CLAIMING MY MEDICAL CONDITION OR INJURY AS A WORKERS' COMPENSATION (WC) CLAIM.**
- ✓ I am declining medical treatment at this time and am fully capable of performing my usual and customary duties.
- ✓ I do not need to complete a DWC-1 at this time.
- ✓ I understand that I am able to change my mind and can file a WC claim within one year from the date of injury (or longer if an exposure or compensable injury).
- ✓ If I do change my mind and want to obtain medical care, I will notify my supervisor, my department's work comp contact, or Risk Management and submit a DWC-1 WC Claim Form at that time.

The information contained in this report is true and correct to the best of my knowledge.	
EMPLOYEE'S SIGNATURE:	**DATE:**
SUPERVISOR'S SIGNATURE:	**DATE:**

For more information you may contact:
City of Petaluma Risk Management 707-778-4568 or 707-776-3781
Keenan Claims Examiner 951-715-0190 ext. 1185
California Division of Workers' Compensation Information & Assistance Unit 800-736-7401

EMPLOYEE INCIDENT REPORT

INSTRUCTIONS FOR FILLING OUT INCIDENT REPORT

Employee:

1. Determine extent and nature of injury. Seek proper first aid or medical attention if necessary.
2. Report injury to immediate supervisor and fill out the Workers' Compensation Claim Form (DWC 1) form and the Employee and Supervisor Incident Report form. Be as specific as possible.
3. Advise your supervisor of any changes in your condition.

Supervisor:

1. Determine extent and nature of injury. Accompany injured employee to doctor if employee is not in condition to drive alone.
2. Offer workers' compensation claim forms to the injured employee as soon as possible.
3. Complete the supervisor's portion of the Workers' Compensation Claim Form (DWC 1) form and the Employee and Supervisor Incident Report form. Be as specific as possible.
4. Determine cause of accident and correct any hazards to prevent re-occurrence.
5. Advise Human Resources of any changes in the employee's condition or when employee returns to work.
6. Replenish any first aid supplies after use. To order more workers compensation injury reporting forms contact the Human Resources department.

If you have any questions or concerns, please contact either:
workcompclaims@cityofpetaluma.org or (707) 776-3781