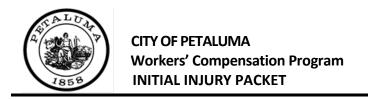


CITY OF PETALUMA Workers' Compensation Program INITIAL INJURY PACKET

	☐ Minor Inju amage/Loss ixposure	ury Lost		/ISOR INCIDENT REPOR Cumulative Trauma
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 REG	ULARLY:			
INCIDENT DATE:	TIME OF INCID	ENT:	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 IN	IJURED:			
EQUIPMENT BEING USED: DESCRIBE IN YOUR OWN WORDS HOW				
NAMES OF WITNESS(ES) TO INCIDENT?				
DESCRIBE THE PROPERTY DAMAGE/LOS	SS, IF ANY:			
WAS THERE AN UNSAFE CONDITION OF DESCRIBE:	R <u>act</u> that cause	D OR CONTRIBUTE	D TO THIS INCIDENT	? YES NO, IF "YES"
DO YOU THINK SOMETHING COULD BE	DONE TO PREVEN	T A SIMILAR INCIDE	ENT IN THE FUTURE?)
lease check whether you ARE or ARE	NOT currently p	resenting a Claim	1:	
I AM PRESENTLY CLAIMING MY M I need a DWC-1 WC Claim F I have been given a DWC-1 I have completed it I will complete it an	orm. WC Claim Form an – to be submitted	d (check one): with Incident Repo		ISATION (WC) CLAIM <u>AND</u> :
I AM NOT PRESENTLY CLAIMING N ✓ I am declining medical trea ✓ I do not need to complete a ✓ I understand that I am able longer if an exposure or complete and the complete a	MY MEDICAL CONE tment at this time a DWC-1 at this tin to change my mir mpensable injury). I want to obtain m	DITION OR INJURY A and am fully capab ne. nd and can file a WO edical care, I will no	ole of performing my C claim within one yo otify my supervisor, i	wpensation (wc) claim. The usual and customary duties. The part from the date of injury (or my department's work comp
	t is true and corre			



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

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