**Workers Compensation Form California**

**Employer Details  
Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employment Status: ☐ Full-time ☐ Part-time ☐ Temporary  
Date of Hire: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**

| **Date of Report** | **Employee Name** | **Date of Injury** | **Location of Incident** |
| --- | --- | --- | --- |
|  |  |  |  |

**Incident Details  
Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
Time of Injury: \_\_\_\_ : \_\_\_\_ AM/PM  
Location of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Describe the incident:**

**Injury Details  
☐ Fracture  
☐ Burn  
☐ Laceration  
☐ Concussion  
☐ Sprain  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you report the injury to your employer? ☐ Yes ☐ No  
If yes, Date Reported: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
Reported to (Supervisor Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Treatment Received? ☐ Yes ☐ No  
Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Certification  
I affirm that the information provided is accurate.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**