**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**