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: ________________

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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: ____ / ____ / _______

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