SEQUOIA UNION HIGH SCHOOL DISTRICT

Workers' Compensation Employee Questionnaire

Employee – Please answer ALL questions completely and honestly. Return to the appropriate person at your site for submission to the District Office.

Personal Information

1. Name: ______________________________ (Last, First) 2. Date: ____________ (MM/DD/YY)

3. Social Security Number: ____________________ 4. Phone #: ____________________

5. Mailing Address: ____

6. Title: ____________________ 7. Supervisor: ____________________

8. Sex: Male Female

Injury/Illness Related Information

9. Date of Injury: ____________ (MM/DD/YY) 10. Time of Injury: __________ AM or PM

11. Part(s) of body affected: ____

12. Location of incident: ____________________ 13. Department: ____________________

14. Describe what you were you doing at time of incident: ____

____

15. Describe what caused your injury/illness: ____

____

16. Were you exposed to blood? Yes No

→ If yes, name of source if known: ______________________________

Medical Treatment Information

** If you need medical treatment and do NOT have a pre-designated physician, obtain a Treatment Referral form from your supervisor to be seen at Kaiser On-The-Job. This ONLY applies if you are filing a workers' compensation claim. If you are NOT filing a workers' compensation claim, seek treatment from your personal physician if necessary.*

17. Are you choosing to file a workers' compensation claim? Yes No
If no, stop here, sign, and date the form.

18. Do you have a valid Pre-Designated Physician form on file? Yes No

19. Do you need a Kaiser On-The-Job Treatment Referral form Yes No

______________________________ ____________________

Employee Signature Date

3/4/14 KG