|  |  |  |  |
| --- | --- | --- | --- |
| **Form Name** | **Completed By** | **Instructions** | **Completed (🗸)** |
| Company Nurse | Employee/  Supervisor | To report any work related injuries  **call Company Nurse at 1-877-518-6710** use code SMCS17.  If employee needs immediate medical attention issue the Kaiser On-The-Job Occupational Health Treatment Referral Form.  Completing the top two lines and signing. |  |
| Covered Employee Notification of Rights Material (3 pages) | N/A | Distribute to employee as reference material (English or Spanish). |  |
| Employee Questionnaire  (1 page) | Employee | Employee completes form and returns to supervisor for submission to D.O. This should be completed even if the employee does not wish to file a workers’ compensation claim. |  |
| DWC 1 – Not Online (1 page) | Supervisor/  Employee | Employee completes questions 1 through 8 and signs on line 9.  Site completed questions 10 through 19 and signs on line 17. |  |
| Employer’s Report of Occupational Injury or Illness (5020) – Not Online | Supervisor/  Employee | Supervisor needs to complete boxes 7 through 29 with employee. Employee can complete as much information that they have for boxes 30 through 39.  \*Supervisor signs bottom of the form. |  |

**Workers’ Compensation Packet**

**Check List**

**Injured Employee:** By signing this form, I agree that I was provided with all of the appropriate forms and was given the option to be treated for my injury at the time I notified my supervisor. I understand that if I do NOT have a pre-designated physician on file with Human Resources, I must be treated by a covered medical provider in order for my medical treatment to be covered under my workers’ compensation claim.