

State of California
 Department of Industrial Relations
 DIVISION OF WORKERS' COMPENSATION



Estado de California
 Departamento de Relaciones Industriales
 DIVISION DE COMPENSACIÓN AL TRABAJADOR

**EMPLOYEE'S CLAIM FOR
 WORKERS' COMPENSATION BENEFITS**

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**PETICION DEL EMPLEADO PARA BENEFICIOS
 DE COMPENSACIÓN DEL TRABAJADOR**

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la División de Compensación al Trabajador llamando al 1-800-736-7401. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee: Empleado:

1. Name. Nombre. _____ Today's Date. Fecha de hoy, _____

2. Home Address. Dirección Residencial. _____

3. City. Ciudad. _____ State. Estado. _____ Zip. Código Postal. _____

4. Date of Injury. Fecha de la lesión (accidente). _____ Time of Injury. Hora en que ocurrió. _____ a.m. _____ p.m.

5. Address and description of where injury happened. Dirección/lugar dónde ocurrió el accidente. _____

6. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. _____

7. Social Security Number. Número de Seguro Social del Empleado. _____

8. Signature of employee. Firma del empleado. _____

**Employer - complete this section and give the employee a copy immediately as a receipt.
 Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.**

9. Name of employer. Nombre del empleador. _____

10. Address. Dirección. _____

11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. _____

12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la petición. _____

13. Date employer received claim form. Fecha en que el empleado devolvió la petición al empleador. _____

14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. _____

15. Insurance Policy Number. El número de la póliza del Seguro. _____

16. Signature of employer representative. Firma del representante del empleador. _____

17. Title. Título. _____ 18. Telephone. Teléfono. _____

Employer: You are required to date this form and provide copies to your insurer or claim administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

State of California	Please complete in triplicate (type, if possible). Mail two copies to:	OSHA Case No. _____
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		<input type="checkbox"/> Fatality

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NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

E M P L O Y E R	1. FIRM NAME		1A. POLICY NUMBER	DO NOT USE THIS COLUMN					
	2. MAILING ADDRESS (Number and Street, City, ZIP)		2A. PHONE NUMBER		Case No.				
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)		3A. LOCATION CODE		Ownership				
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		Industry				
	6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____				Occupation				
E M P L O Y E E	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yy)	Sex				
	10. HOME ADDRESS (Number and Street, City, ZIP)		10A. PHONE NUMBER		Age				
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)		13. DATE OF HIRE (mm/dd/yy)		Daily hours			
	14. EMPLOYEE USUALLY WORKS hours _____ days _____ total per day _____ per week _____ weekly hours		14A. EMPLOYMENT STATUS (check applicable status at time of injury) regular _____ full-time _____ part-time _____ temporary _____ seasonal		14B. Under what class code of your policy were wages assigned?		Days per week		
	15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO		Weekly hours				
I N J U R Y O R I L L N E S S	17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)		18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.		19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.		20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		Weekly wage
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yy)		23. DATE RETURNED TO WORK (mm/dd/yy)		24. IF STILL OFF WORK CHECK THIS BOX <input type="checkbox"/>		County
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Nature of injury
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.								Part of body
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)			30A. COUNTY		30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		Source	
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.					32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Event
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.								Sec. Source
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.								Extent of injury
	35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.								
	36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)						36A. PHONE NUMBER		
37. IF HOSPITALIZED AS AN INPATIENT. NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)						37A. PHONE NUMBER			

Completed by (type or print)	Signature	Title	Date
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