WORKERS' COMPENSATION

Claimant's Report of Injury Form

In order for the District to expedite your claim promptly, please complete the form in its entirety and return it to the address below:

FOOTHILL – DE ANZA COMMUNITY COLLEGE DISTRICT
Attn: Christine Vo, HR Dept.
12345 El Monte Rd
Los Altos Hills, CA 94022
Tel: (650) 949 – 6225 FAX: (650) 949-2831 E-Mail: VoChristine@fhda.edu

State your full name: ____ Date of birth: ____________________

Address: ____ Phone #: ( )________-________

(No. & Street) (City) (State) (Zip)

Male / Female SS#: ___________-________-___________ Date of hire: _____________________

Job title: ____ Dept.: ___________________________

Are you a student intern? _____Yes _____No Name of Program: ______________________________

Supervisor's name: ____ Phone #: ( )________-________

How many hours do you work per day? ____________________ Per week? _________________________

What is Your gross salary? $_________________ _____Per month _____Per hour N/A ________

Full-time/benefits:__________ Full-time/no benefits:___________ Part-time:________ Seasonal:_______

Date of injury: ________________________________ Time of injury: _________________(a.m. / p.m.)

Exact location of your accident/exposure: ____

Time you began work on the day of your injury: _____________________________________(a.m. / p.m.)

Did you miss at least one full day of work after your injury? _____Yes _____No

Date last worked: ____________________________ Date returned to work: _________________________

Were you on the District's premises at the time of your injury? _____Yes _____No

Describe your injury (i.e. cut, strain, fracture, etc.): ____

Part of body affected (i.e. back, left wrist, right eye, etc.): ____

Was your injury caused by a third person(s)? _____Yes _____No

If yes, list name(s)? ____

Describe in detail about what happened to you at the time of your injury. If lifting was involved, give estimated weight of object lifted. Use additional sheet(s) if necessary:

____

____

____

Name, address, and phone number of physician treating you for this injury ___________________________________

____

If hospitalized, give name & address of hospital: ____

____

(OVER)

Was anyone else present at the time of your accident? _____Yes _____No

If yes, list name(s): ____

Did you tell anyone that you were injured at the time of your accident? _____Yes _____No

If yes, list name(s): ____

Did you feel pain at the time of your injury? _____Yes _____No

If yes, where? ____

Who did you report your injury to? ____

If you did not report your injury, explain why: ____

Were you sent to a doctor for your injury or did you go on your own? ______________________

Name & address of your family physician: ____

____

Have you seen him regarding your present injury? _____Yes _____No

If yes, when? ____

Are you disabled because of your injury? _____Yes _____No

Are you disabled for any other reasons? _____Yes _____No

Have you ever been hospitalized for a similar condition? _____Yes _____No

If yes, when? ____

Where? ____

When did you last see a physician before your present injury? ______________________

Physician's name & address: ____

Reason for physician visit(s): ____

Second employer: Name: ____

Address: ____

Phone #: ( ) _________ - ___________ ext.: __________

Please make any additional remarks regarding your claim:

____

____

____

____

Signature: ______________________________ Date: ____________________

Updated – 09/06