WORKERS' COMPENSATION SUPPLEMENT
(TO BE FILED WITH EMPLOYEE'S DWC1 CLAIM FORM)

Name: _____ Date of Birth: _____

PHONE NUMBER: _____ EMPLOYEE ID #: _____

JOB TITLE: _____Site/Dept. that injury occurred: _____

Assigned site (if different): _____ Normal work schedule: _____

Date of injury: _____ Date you reported to Supervisor or Risk Management: _____

Time of injury: _____ am/pm Time you began work: _____ a.m./p.m.

Supervisor's name and phone #: _____

What were you doing when the injury occurred? **(Be specific, identify tools, equipment, etc. you were using.)**

_____

_____

How did the accident or exposure occur? **(Be specific. Identify tools, equipment, etc. you were using.)**

_____

_____

Describe injury (i.e. cut, strain, fracture, rash, etc.) _____
Body affected (i.e. left wrist, right eye, etc.) _____
Object or substance that directly injured employee _____
Are you going to the doctor? _____ If so, date_____
Do you have a PRE-DESIGNATED PHYSICIAN on file? _____

MEDICAL TREATMENT: Stockton Unified School District employees who file a Workers' Compensation claim must be treated at one of the below clinics unless there is a pre-designated form on file prior to injury.

KAISER OCCUPATIONAL	**TRINITY OCCUPATIONAL**
7373 W. Lane, 1st Floor	**10200 Trinity Parkway**
Stockton, CA 95210	**Stockton, CA 95219**
(209)476-3694	**(209) 955-1229**
M-F, 8:00 am – 5:30 pm	**M-F, 8:00 am – 5:00 pm**
Lunch 12:30 - 1:30 pm	

Attention for new patients/injuries: first visit must be at clinics by 4:00 pm or will be seen the next work day

I understand that under the provision of Section 550 of the California Penal Code which provides that it is a felony to knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss, including payment of a loss under a contract of insurance and also it is a felony to knowingly assist, abet or conspire with any person who knowingly presents any false or fraudulent claim for the payment of a loss, including payment of a loss under a contact of insurance.

List All witnesses: _____

Employees Signature: _____ DATE: _____