



# "Employee" On the Job Injury/Illness Report

("Employee" Includes Volunteers, Explorers, AWP's & Inmate Work Crews)

**Fax Immediately and Forward Original Within 24 Hours to:**

Stanislaus County, CEO-Risk Management Division

1010 10th Street, Suite 5900, Modesto, CA 95354

Phone: (209) 525-5710 Fax: (209) 525-5779

Faxed on \_\_\_ / \_\_\_ / 20\_\_\_ at \_\_\_\_\_ am / pm by \_\_\_\_\_

**SUPERVISOR COMPLETE THIS SECTION**

<b>Date and Time of Injury:</b>	<b>Date Reported:</b>	<b>DWC-1 Provided On:</b> (To Be Completed <b>ONLY</b> if Seeing a Dr.) / / 20___
Accident Reported to:	Case #	<b>MPN Brochure Provided On:</b> / / 20___
First Aid Administered by:	Agency Name:	
Clinic or Hospital Sent To:	Length of Stay ___ Hours Check Here if Admitted: <input type="checkbox"/>	
Medical Attention Authorized by:	Authorization Treatment Form Given to Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Identify Witnesses:	Statements Attached: <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> To Be Completed and Forwarded	
Possible Ways to Prevent Reoccurrence per Supervisor's Investigation: Also indicate any preventative action already taken.		

Time Began Work: \_\_\_ am / pm Time Left Work: \_\_\_ am / pm Time Returned to Work: \_\_\_ am / pm

Lost Days (circle) Yes No Date last worked \_\_\_\_\_ Date returned to work \_\_\_\_\_

On-Site Supervisor: (Printed Name) Phone: \_\_\_\_\_ Department: \_\_\_\_\_

**EMPLOYEE COMPLETE THIS SECTION**

Name:	ID #	Date of Birth:
Mailing Address:	Please include city, state & zip	Home Phone # Work Phone #
Sex: Male / Female	Job Title:	Social Security #

Employment Status: (Check One) \_\_\_ Regular Full-time \_\_\_ Part-time \_\_\_ Temporary \_\_\_ Seasonal

Other:  Inmate, AWP, Volunteer, etc. Date of Hire or Incarceration: \_\_\_\_\_

Normal work hours (8:00 am to 5:00 pm Monday thru Friday) : \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_ thru \_\_\_\_\_.

**Location where accident or exposure occurred:** Please be specific, list department, address, location within building, etc.

**What were you doing when injured?** Please be specific, identify tools, equipment or materials that you were using.

**How did the accident or exposure occur?** Please describe in full the events that resulted in the injury or illness. Explain what happened.

**EMPLOYEE COMPLETE THIS SECTION CONTINUED**

**Describe the object or substance that directly injured you:** e.g., the machine used or the chemicals that you were exposed to.  
For strains, describe what you were lifting, pushing, pulling, etc.

**Describe the injury or illness:** e.g., cut, strain, fracture, rash, etc.

**Part of body affected:** e.g., lower back, left wrist, right eye, etc.

(Include the "Sharps Injury Log" form and/or the "Employee Exposure Report" form as applicable)

**MPN Medical Facility:** For a full MPN provider list go to: <http://www.hmcmpn.com>, use employee code STANMPN

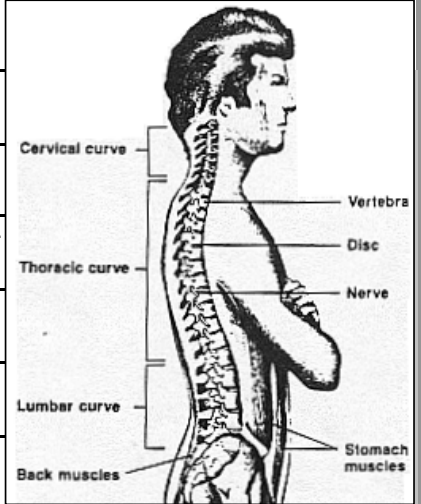
- California Occupational Physicians, 2112 McHenry Ave., Modesto 209-572-2114
- Kaiser Occupational Clinic, 4601 Dale Rd., 4th Floor, Modesto 209-735-4121
- Sutter Gould Occupational Physicians, 600 Coffee Rd., Modesto 209-521-6038
- US Health Works, 1524 McHenry Ave., Suite 500, Modesto 209-575-5801
- Approved qualified Pre-designated personal physician in accordance with LC4600(d) - on file with the County.

Dr. \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**All medical treatment MUST be preauthorized and subject to treatment guidelines set forth by the American College of Occupational and Environmental Medicine (ACOEM) and the provision of the California Labor Code. Medical treatment should be sought from one of the above listed County's designated medical facilities.**

**Complete for Back Injury ONLY!**

1. Describe what area of your back still hurts.
2. Describe the back pain you are experiencing.
3. Describe what you were moving; size, weight, etc.
4. Describe the methods used in moving; lifting, reaching, twisting, bending, pushing, pulling, etc.
5. Describe any previous or on-going back trouble you have.
6. List Doctors you have seen for back problems.
7. What can you do to prevent further back injury?



**Additional Comments:**

**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 worker's compensation benefits is guilty of a felony.**

***The above statements made by me are true and correct to the best of my knowledge.***

**Signatures:**

**Employee:**

**Date:**

**Supervisor:**

**Date:**