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: Benefits Unit, HR Dept.
12345 El Monte Rd
Los Altos Hills, CA 94022
Tel: (650) 949 – 6224 **FAX: (650) 949-6299** **E-Mail: MyBenefits@fhda.edu**

State your full name: _____ Date of birth: _____

Address: _____ Phone #: _____
(No. & Street) (City) (State) (Zip)

Male ☐ Female ☐ SS#: _____ CWID: _____ 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