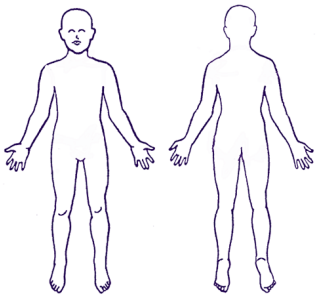
CALIFORNIA
J · P · I · A

Employee's Report of Injury or Illness

1. Employee's name (please print)	2. Birth date	3. Social Security #
4. Employer's name	5. Job title, duties or position	6. Department
7. Date and time of injury or illness	8. Location of injury or illness	On employer property? ☐Yes ☐ No
9. What you were doing when the injury or illness occurred?		
10. How did the injury or illness occur?		
11. Describe the injury or illness (body parts, condition)		Mark affected area(s) on this diagram 
12. Supervisor's name	13. Who did you report the injury or illness to?	14. Did you get a claim form (DWC-1)? ☐Yes ☐No 15. Did you return the claim form? ☐Yes ☐No
16. List all witnesses		
17. Have you ever had any injury or illness to this part of your body before now? ☐Yes ☐No (If "no", skip to 19)		
18. Please explain any previous condition that may have been aggravated by this incident		
18a. List the name and addresses of all medical providers you have seen for these previous conditions		
19. Do you feel something could have been done to prevent this accident? If "yes", explain.		
20. Describe any safety hazards you observed		

I currently refuse medical treatment.

Employee's signature _____ Date _____

I certify that the foregoing is true and correct:

Employee's signature _____ Date _____

Employer's representative's name _____ Date _____

Employer's representative's signature _____