Print Form | Submit by Email

TO BE COMPLETED IMMEDIATELY! The district/college employee who either witnesses the injury or is supervising the injured person at the time of injury/incident should complete this form immediately. The report should be submitted to Administrative Services the same day. Should other pertinent facts develop, notify Administrative Services by means of a supplemental report. **FOR EMPLOYEE INJURIES, CONTACT THE CAMPUS PERSONNEL SERVICES OFFICE IMMEDIATELY.**	*This report is for the confidential use of District and legal counsel for the District and its employees in defending litigation.* * * * * * * * *	**STUDENT/NON-STUDENT ACCIDENT/INCIDENT REPORT**

District **Coast Community College District**	College/Location	
College/Location Address		Phone No.
Injured's Name	ID #	Birthdate
Home Address		Phone No.
Where did the incident occur?	Date	Time
How did the incident occur?		

Nature of injury		
First aid applied ○ Yes ○ No	By whom?	Disposition of injured person (return to class, home, doctor, hospital)
Does injured person have own medical Insurance coverage? ○ Yes ○ No		Name of Insurance Company
Was any district rule violated? ○ Yes ○ No	If so, explain. Comment on supervision.	

Witnesses present at time of incident

Name	Address	Phone No.

Has anyone contacted school? If yes, explain below. ○ Yes ○ No	Was family contacted by school? If yes, explain below. ○ Yes ○ No	Was family or injured person told they would be contacted again? Explain below. ○ Yes ○ No
Comments		

Report submitted by	Position	Date	VP Administrative Services	Date

ORANGE COAST COLLEGE

WORKERS' COMPENSATION INFORMATION SHEET

RE: Employee / Student Name: _____
Employer: Coast Community College District
Claim#: _____
Date of Injury: _____

In order to assist us in processing your workers' compensation claim, we need you to complete and sign the enclosed Medical Release Authorization and Medical History forms. We would appreciate your returning these forms promptly.

Also, please advise of any prior Workers' Compensation Awards or Permanent Disability Ratings you may have received.

Thank you for your consideration in this matter.

Enclosures

WC FORM #2

ORANGE COAST COLLEGE

MEDICAL CLAIM HISTORY OF:

RE: Employee / Student Name: _____
Employer: Coast Community College District
Claim #: _____
Date of Injury: _____

For the purpose of having a complete medical history to provide your treating doctor, please complete the bottom of this sheet to the best of your ability. If you have been treated at a Kaiser facility, please include your medical record number and the names of the physicians who have treated you. Also, if you are a Medicare recipient, please include your Medicare card number or HIC number.

During the past ten years, I have received medical treatment at the following:
(Please proved the names of Hospital/Physician, Address, Body Part and Year of Treatment)

1.

2.

3.

4.

5.

6.

7.

8.

Have you ever had a prior workers' compensation award or disability? Yes or No (please circle) if yes, please explain and provide the name of the employer and the physician who made the determination of your disability.

WC FORM #3

ORANGE COAST COLLEGE

OCC EMPLOYEE'S / ALLIED HEALTH STUDENT REPORT OF INJURY

YOUR NAME:			
Home Address:		Social Security #:	
Date of Hire:		Phone Number:	
Job Title:		Date of Birth:	
Circle One:	**Employee / Allied Health Student**	Date of Injury/Exposure/Occurrence:	

Time you started work: _____ **Time Injury Occurred:** _____

Circle Employment Status:	**Full-time / Part-time / Temporary / Allied Health Student**

Were you unable to work at least one full day following date of injury/occurrence? (Please circle): YES or NO

Date last worked/scheduled:		Date Returned to Work:		Days Missed:	
Work / Allied Health Clinic Schedule:		Hours per day:		Days per week:	

Please state specific injury/exposure/occurrence: _____

Part(s) of Body affected: _____

Location where the injury/exposure/occurrence occurred: _____
***If it was not on OCC campus please provide location name & address:*
_____

Specify Department: _____

Equipment, materials, & chemicals being used at time of injury/exposure/occurrence:
_____

Specific activity being performed at time of injury/exposure/occurrence:_____

How did the injury/exposure/occurrence occur? Describe the sequence of events. Specify the object or exposure which directly produced the injury/exposure/occurrence.
_____
_____
_____
_____

Date of employer knowledge: _____
Date claim form provided: _____

WC FORM # 4

State of California
Department of Industrial Relations
DIVISION OF WORKERS COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer at time of hire describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información grabada. En la hoja cubierta de esta forma está la explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador al tiempo de ser empleado un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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 workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee--complete this section and see note above ***Empleado--complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer--complete this section and see note below. ***Empleador--complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleador devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros a agencia administradora de seguros.* _____
15. Insurance Policy number. *El número de la póliza del seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un dia hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Keenan & Associates 8/2004

EMPLOYER'S COPY