Catholic Charities of Los Angeles, Inc.

CATHOLIC CHARITIES OF LOS ANGELES, INC.

INITIAL REPORT OF INJURY OR ILLNESS

DATE FIRST REPORTED: _____ TIME: _____ AM PM

DATE OF ACCIDENT: _____ TIME: _____ AM PM

INJURED EMPLOYEE NAME: _____

ADDRESS: _____
Street City Zip Code

PHONE # ( ) _____ HOME

PHONE # ( ) _____ WORK

PLEASE ANSWER THE FOLLOWING:

Department in which regularly worked: _____

Is Employee: _____ Regular _____ Part Time _____ Other

Where did the accident occur? _____

What was the employee doing when the accident occurred?

_____

_____

How did the accident occur? (Describe fully the events that resulted in injury. Tell what and how it happened.)

_____

_____

_____

Describe the injury or illness. (i.e. cut, sprain, rash, etc.)

_____

_____

What part of the body was affected? (i.e. left wrist, right index finger, lower back, etc.)

_____

_____

Was first aid given? Yes ____ By: _____ No ____

Was CPR given? Yes ____ By: _____ No ____

Was the person sent to a Health Center? Yes ____ No ____

If hospitalized, provide name and address of hospital:

_____

_____

If hospitalized, provide name of Physician:

_____

Did the employee lose at least one full day of work after and as a result of the injury?

Yes ____ Date returned back to work: _____ No ____

Did the employee return from injury? Yes ____ Return Date: _____ No ____

Did the employee receive the employee claim form (DWC-1)? Yes ____ No ____

Date claim form given to employee: _____ By: _____

Signature of injured person _____

IF THE INJURED PERSON REFUSED MEDICAL ATTENTION, PLEASE HAVE HIM/HER READ AND SIGN BELOW.

I, THE UNDERSIGNED DO HEREBY REFUSE MEDICAL TREATMENT FOR THE ABOVE DOCUMENTED INJURY OR ILLNESS.

_____

SIGNATURE OF INJURED PERSON DATE

FORM VERIFIED BY: _____

Supervisor Dept.

DATE: _____ TIME: _____ AM PM

Provide a brief statement of injury:

_____

_____

_____