STATE COMPENSATION INSURANCE FUND

Claim No. _____

Injured's Name _____

EMPLOYEE'S REPORT OF INJURY

IMPORTANT: Prompt adjustment of your claim requires COMPLETE and FULL ANSWERS TO ALL THE QUESTIONS appearing below. To avoid delay complete this form and mail to the above address at once.

Name of your employer _____
(Give full name of person or firm for whom you were working when injured)

Are you related to employer by blood or marriage? ☐ Yes ☐ No If yes, give relationship _____

Occupation when injured _____ (Job Title) Date of Birth ___/___/___ (Month / Day / Year)

Rate of pay when injured $ _____ (Per Hour, Day, Week or Month) Hours worked per day _____ for _____ days per week

In addition to wages did you receive any other advantages such as board, lodging, tips, bonuses? ☐ Yes ☐ No If yes, describe and

give estimated value _____ (Type of Advantage) $ _____ per _____ (Estimated value per Day, Week or Month)

Date of Injury ___/___/___ (Month / Day / Year) Hour _____ Date last worked ___/___/___ (Month / Day / Year)

Where did injury occur? (Location) _____ (Number and Street) (City) (County)

Was your injury caused by another person ☐ Yes ☐ No If yes, give name and address of person responsible _____

_____

How did the injury happen? (Describe fully, stating whether you fell, were struck, etc., give all factors contributing to accident)

_____

_____

Give names and addresses of any witnesses to your injury _____

_____

Describe in detail the nature of your injury and the part of your body affected _____

_____

Before this accident did you ever suffer from any injury or disease? ☐ Yes ☐ No If yes, give details on reverse side of form.

Was medical treatment required because of your injury? ☐ Yes ☐ No

If yes, who is your physician? _____ Address _____

Is this a personal physician designated by you to your employer prior to your injury? ☐ Yes ☐ No

If yes, has this personal physician treated you before? ☐ Yes ☐ No

Have you returned to work? ☐ Yes ☐ No If yes, give date _____ At what wage? $ _____ per _____ (Hour, Day, Week)

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Injured _____ (First Name) (Middle Initial) (Last Name) Date _____

Address _____ (Number and Street) (City)

Telephone (___) _____ Social Security No. ___-___-___