State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

DWC 1 Form

Please Note:

This form is a 4-part Carbonless NCR Form that can only be obtained from FCEOC Human Resources Office

WORKERS' COMPENSATION CLAIM FORM (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 signed and 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 describing workers' compensation benefits and the procedures to obtain them.

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.

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 occurió 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 empleado devolvió la petición al empleador.* ______
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    State Compensation Insurance Fund
15. Insurance Policy Number. *El número de la póliza de 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 día 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*

Obtain from HR

SCIF 3301 (REV. 7-04) · DWC Form 1 (REV. 7-04)

STATE COMPENSATION INSURANCE FUND