

PALMDALE SCHOOL DISTRICT

EMPLOYEE REPORT OF INJURY

**IF THIS IS A SERIOUS INJURY
DIAL 911 IMMEDIATELY FOR PARAMEDICS**

If a non life-threatening injury occurs:

Injured employee (along with Supervisor, if possible) calls: 24/7 WORK INJURY NURSE LINE for CorVel Insurance to report at:

1-877-764-3574

Give employee DWC1 Claim form and employee should complete the following:

Name of injured employee: _____ School Site/Dept: _____

Title/Position: _____ Injured's phone #: _____ Date of Injury: _____

Injured's work shift: _____ What body part is injured? _____

Describe in detail how the injury occurred: _____

Names of any and all persons present at the time of the accident: _____

Did a hazardous condition cause the accident/injury? If yes, describe: _____

How long has the hazard or hazardous condition been present? _____

To whom had the hazard been reported? _____ When? _____

Was there a work order submitted to repair the condition? _____ WO#: _____

Were safety rules or procedures violated causing this injury? _____

How could this injury have been prevented? _____

OVER

Will the injured seek medical attention for this injury? ____ Yes ____ No ____ Undecided

Please provide the injured employee the DWC1 form. Complete the DWC1 form if employee seeks medical attention. Employee retains back copy of DWC1 form. These forms must be returned to the District Office, attention Risk Management.

Does the injured employee have a pre-designated doctor on file with the district? ____ Yes ____ No

Name of doctor: _____

Please contact Dawn Schmucker at ext. 6547 or Ashley Hoffman at ext. 6548 to get authorization prior to seeking treatment with your personal physician.

If no predesignated doctor is on file, injured party must see the district's physician. District reserves the right to have employee first examined by the District physician regardless of pre-designation.

Medical Services Provider

ProActive Work Health Services

39251 10th St. West, Palmdale 661-274-2000 (if treating **before 4 pm**)
(located south Mister Car Wash; in former YMCA BLDG)

OR 44451 16th Street West, Lancaster 661-945-5999 (treatment after 4 pm ONLY)

Employee complete:

- I have received a DWC1 Claim form.
- I have not received a DWC1 Claim form, please mail one.
- I do not wish to file a claim under Workers' Compensation and decline a DWC1 form.

Employee must receive a DWC1 Claim form within 24 hours of report or injury (4 part NCR). Employee retains the front information page and the back copy, all other pages to Risk Management at the District Office.

My signature below acknowledges that in accordance with Labor Code Section 4616, the Palmdale School District provides medical treatment for a work-related injury or illness through EIA MPN (Excess Insurance Authority Medical Provider Network). **MPN ID# 1163.**

Signature of injured employee

Date

Print name of person completing this form

Title

Site Administrator: Print and sign name

Date

24/7 WORK INJURY NURSE LINE CONFIRMATION # _____

Please send this original form and DWC1 (if completed) to Risk Management, at the District Office. Call extension 6547 or 6548 with any questions. Thank you.