RECEIPT OF WORKERS' COMPENSATION CLAIM INFORMATION

Employee Name: _____

Department: _____

Date of Injury: _____

Date Forms/Information Received: _____

I hereby acknowledge I have received, read, and understand the following:

(Initial each line prior to form received)

___ Employee Claim Form (DWC-1)

___ Workers' Compensation Handbook

___ How to File a Worker's Compensation Claim

___ Authorization for Medical Treatment Form

___ Medical Provider Network Pamphlet

Employee's Signature:_____

THIS SECTION TO BE COMPLETED BY SUPERVISOR

Date Supervisor had Knowledge of Injury:_____

Time Supervisor was notified of Injury: _____

Date Claim Packet Provided to Employee:_____

Signature of Supervisor: _____

Print Name of Supervisor: _____

Telephone No.: (209) _____