CITY OF MILPITAS

Manager's/Supervisor's Report of Employee Injury or Illness

This report must be completed by the manager/supervisor when there is a notice or knowledge that an employee has sustained an injury or illness that may be work-related. The Workers' Compensation Claim Form (DWC 1) must be provided to the injured worker within 24 hours of knowledge of incident. This form can be found online at: https://www.dir.ca.gov/dwc/dwcform1.pdf

Date of Employer's Knowledge/Notice of Injury/illness:	Date Employee was provided the Employee Claim Form (DWC-1) (attach completed form if available)		
Employee Name:	Job Title:	Department:	
Employee Usually Works: _____ Hours/day _____ Days/week _____ Total Weekly Hrs.	Employment Status _____ Regular Full Time _____ Temporary ____Cont. _____ Regular Part Time _____ Volunteer		
Date of Injury or Onset of Illness:	Time Injury/Illness Occurred: a.m. p.m	Time Employee Began Work: a.m. p.m	If employee died, date of death:
Location where event or exposure occurred (if possible specify location such as building and room):			
Specific injury/illness and part of body affected:			
Equipment, materials and chemicals the employee was using when event or exposure occurred:			
What unsafe act(s)/conditions caused the accident?			
_____ Excessive or improper lifting	_____ Congested work area		
_____ Unsafe clothing or footwear	_____ Unauthorized activity		
_____ Unsafe floor or stair condition	_____ Override of safety device		
_____ Safety procedure not followed	_____ Unsafe driving		
_____ Unstable piling or stacking	_____ Improper use of equipment		
_____ Unpreventable	_____ Other		
Medical Treatment _____ Medical Treatment Declined _____ First Aid in Department _____ Alliance _____ Kaiser on the Job _____ U.S. Healthworks _____ Employee was transported to hospital by ambulance to hospital _____	_____ Pre-designated Physician _____ _____ Paramedic _____ Employee treated in emergency room _____ Employee was hospitalized overnight		
What action(s) have been, will be or could have been taken to prevent reoccurrence?			
What was the employee doing when the injury occurred?			
Did injury/illness cause absence from work? _____ Yes _____ No	Has employee returned to work? _____ Yes _____No Date last worked_____		
Name of Witness	Phone Number		
Print Manager/Supervisor Name	Title	Extension	Date