

# **Workers' Compensation Claim Kit**

## **Instructions for Completing the Forms Required to Report a Work-Related Injury or Illness**

### California Department of Human Resources Workers Compensation Program

#### **What are Your Responsibilities?**

The department is responsible for reporting a work-related injury or illness suffered by an employee. These responsibilities include but are not limited to the following:

- Arrange transportation or personally accompany the employee to the physician's office or hospital;
- Provide the employee with Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility form (e3301) within one working day of notice that a work-related injury or illness may have occurred;
- Complete an Employer's Report of Occupational Injury or Illness form (e3067) for all injuries resulting in lost time beyond the date of injury or medical treatment beyond first aid; (Labor Code §9780, subd. (d)), "first aid" is any one-time treatment, and a follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care.)
- Ensure that the e3301 and e3067 are forwarded to State Compensation Insurance Fund (State Fund) within the required timeframes.
- Maintain contact with your injured employee.

#### **The following items are included in this package:**

- Description of forms.
- Actions to take when an injury occurs.
- Instructions for completing the Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility (e3301) and the Employer's Report of Occupational Injury or Illness (e3067).
- Attachments – Employee's Acknowledgment of Receipt, Witness Contact Sheet, and Customer Service Center Fax Cover Sheet (updated July 2012).

## DESCRIPTION OF FORMS

### **Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility e3301 (rev. 01/12) DWC 1 (rev. 6/10)**

This fillable form is available on the State Fund (State Agencies) web site:  
<http://www.statefundca.com/statecontracts/Forms.asp>

You must provide the claim form to your injured or ill employee within one working day of receiving notice that a work-related injury or illness has occurred. The first pages are the employee's Notice of Potential Eligibility, it provides information regarding workers' compensation benefits to which the employee may be entitled.

We recommend that you also provide the I've Just Been Injured on the Job, What Happens Now? brochure to the employee along with the claim form. This brochure is available on the workers' compensation program web site at the following address:  
<http://www.calhr.ca.gov/state-hr-professionals/Pages/workers-compensation-program.aspx>

Provide the claim form to your employee in the following situations:

- A work-related injury or illness has occurred that requires medical treatment beyond first aid or that results in lost time beyond the employee's work shift on the day of injury.
- An employee informs you that he or she has suffered an injury or illness. The claimed injury or illness does not have to be witnessed.
- An employee presents a doctor's note stating that a work-related injury or illness may have occurred.
- An accident occurs on state property involving a State employee.
- An accident occurs involving a state employee conducting state business whether on state property or not.

Providing the claim form is not an admission of liability. An employee uses the claim form to report a work-related injury or illness and to describe how, when, and where the claimed injury or illness occurred.

If you are unable to hand deliver the claim form to the employee, it must be sent by first-class mail to the mailing address on file for the employee.

## **Acknowledgement of Receipt of the Claim Form**

This form can be used to document that your department provided the employee with the claim form (e3301) within one working day of receiving notification of the work-related injury or illness.

## **Employer's Report of Occupational Injury or Illness e3067 (REV. 8/10)**

This fillable form is available on the State Compensation Insurance Fund web site: <http://www.statefundca.com/statecontracts/Forms.asp>

State Fund must receive the employer's report within five calendar days of the employer's knowledge or notification that a work-related injury or illness has occurred. You must submit an employer's report in the following situations:

- A work-related injury results in lost time beyond the date of injury or medical treatment beyond first aid.
- An employee presents a doctor's note stating that an injury or illness is or may be work related.
- You receive a completed claim form sent by an attorney, employee, doctor, or State Fund office.

Completion of the employer's report is not an admission of liability. By filling it out, you document the facts or allegations regarding the injury or illness reported by the employee. All injuries or illnesses need to be reported to the Return-to-Work Coordinator or person who is responsible for handling workers' compensation issues within your department. Notify State Fund immediately if an employee has reported a questionable injury or illness.

You do not need to submit the employers' report for injuries or illness that only require first aid or that don't result in lost time beyond the date of incident.

## **Witness Contact Sheet**

The Witness Contact Sheet can be used to report the names and phone numbers of witnesses to a claimed injury or illness. It is important that you report witness information to your State Fund adjuster as soon as possible. Although we recommend using the attached Witness Contact Sheet, you may instead use memorandum, departmental letterhead, e-mail, or other forms of written documentation to relay this information to State Fund.

# **ACTIONS TO TAKE WHEN AN INJURY OCCURS**

## **WHEN NOTIFIED OF A POTENTIAL INJURY OR ILLNESS:**

1. Provide claim form (e3301) to employee within one working day.
2. Document action with Acknowledgement of Receipt or other memo.
3. Complete employer's first report of injury and gather witness and other pertinent information immediately.

## **WHEN A COMPLETED CLAIM FORM (e3301) IS RECEIVED:**

1. Complete the employer's section and provide a copy of the completed form to the employee immediately.

## **TO REPORT THE INJURY OR ILLNESS TO STATE FUND:**

1. Complete the employers' first report of injury on line and submit via Electronic First Report of Injury (EFROI) within 5 days of notice.
2. Then fax all other claims information directly to your State Fund adjuster immediately after receiving the claim number.

or

1. Fax the completed employers' first report of injury (e3067) and completed claim form (e3301) together to the Customer Service Center (CSC) using the attached fax cover sheet within 5 days of notice.
2. Then fax all other claims information directly to your State Fund adjuster immediately after receiving the claim number.

EFROI is the preferred method of reporting claims to State Fund and is available for all departments who have access to State Fund Online (SFO).

For initial access to SFO contact Mindy Chan at [mmchan@scif.com](mailto:mmchan@scif.com).

## **INSTRUCTIONS FOR PREPARING THE WORKERS' COMPENSATION CLAIM FORM (DWC 1) E3301**

The claim form must be provided to an employee within one working day of receiving notice of a work-related injury or illness.

### **Employee's Section** (completed by employee or their representative)

1. **Name and today's date** - Employee's name and the date the employee completed the form.
2. **Home address** - Place of residence.
3. **City/State/Zip** - Corresponding to the employee's home address.
4. **Date of Injury/Time of Injury** - For a specific injury the date and time of injury is when the event occurred. For a cumulative trauma injury, the date and time of injury is the employee's date of knowledge that an injury has occurred.
5. **Address and description of where injury happened** - The physical address and specific location where the injury or illness occurred.
6. **Describe injury and part of body affected** - Specific details regarding the injury and body part affected.
7. **Social Security Number (SSN)** - Employee's SSN is required.
8. **Signature of employee** - Employee's signature. If the employee is unable to sign, then it can be submitted with a representative's signature or without signature. The claim form serves to initiate the claim's process and no signature is required.

### **Employer's Section** (completed by the employer representative)

9. **Name of employer** - Enter Department/Agency name.
10. **Address** - The department/agency address where the form was completed.
11. **Date employer first knew of injury** - The date the employer was notified that an injury or illness has occurred.
12. **Date claim form was provided to employee** - The date the employee was either handed or mailed the claim form.
13. **Date employer received claim form** - The date the employee returned the claim form with their section completed.

14. **Name and address of insurance carrier or adjusting agency** - State Compensation Insurance Fund is pre-filled on form.
15. **Insurance policy number** - Department/Agency Code
16. **Signature of employer representative** - The person who completed the employer section.
17. **Title** - Title of the employer representative completing the employer section.
18. **Telephone** - The contact number for the employer representative.

## **INSTRUCTIONS FOR PREPARING THE EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS E3067**

This form is completed by the employer based on the initial investigation of the claimed injury or illness.

Under no circumstances should the injured or ill employee complete this form.

### **Top Section**

**OSHA case number** - LEAVE BLANK

### **Employer Section**

1. **Department** - Enter Department Name/Unit Name.
- 1a. **Agency code or SCIF policy number** - Enter Agency Code.
2. **Mailing address** - Enter Mailing Address (Location of the Departmental Workers' Compensation Unit).
- 2a. **Phone number** - Enter reporting Unit Phone Number (Include Area Code).
3. **Location, if different from mailing address** - Enter Reporting Unit Office Address.
- 3a. **Division/Location code** - Enter the division/location code.
4. **Nature of business** - The employer's function.
5. **State unemployment insurance account number** - LEAVE BLANK.
6. **Type of employer** - "State" is pre-checked on form.

## **Injury or Illness Section**

7. **Date of injury or onset of illness** - Enter date injury or illness occurred, or was reported to have occurred.
8. **Time injury or illness occurred** - Time employee became ill/Injured.
9. **Time employee began work** - Time employee started work on the date of the injury. If unknown, leave blank.
10. **If employee died, date of death** - If the employee died, then you must immediately notify the Cal/OSHA Enforcement Unit District Office by phone.
11. **Unable to work for at least one full day after date of injury** - Enter "Yes" if it is known that there will be or was absences from work (other than the date of injury). Enter "No" if it appears that there will be no absences (other than the date of injury).
12. **Date last worked** – The last date the employee worked.
13. **Date returned to work** - Enter Date employee returned to work.
14. **If still off work, check this box** - Mark this box if the employee has not returned to work.
15. **Paid full wages for day of injury or last day worked?** - Enter "Yes."  
Administrative Time Off (ATO) is granted for any time lost on the date of injury.
16. **Salary being continued?** - Enter "Yes" if employee will continue to be paid past the date of injury. (e.g., leave credits, returned-to-work, etc.)
17. **Date of employer's knowledge/notice of injury or illness** - Enter date injury/illness was reported or witnessed.
18. **Date employee was provided Workers' Compensation Claim Form (DWC 1)**  
- Enter the date the form was given or mailed to the employee.
19. **Specific injury or illness and medical diagnosis** - Indicate the nature of the injury/ illness.
- 19a. **Body Part Affected** - Use the exact part(s) of body injured. Include left or right, upper or lower, etc.
20. **Location where event or exposure occurred** - Enter address or location where incident occurred.

- 20a. Zip** – Enter zip code where the incident occurred.
- 20b. County** - Enter the County where the incident occurred.
- 21. On employer's premises?** - Enter "Yes" or "No" according to where incident happened.
- 21a. Was another person responsible?** Enter "Yes" or "No" according to nature of incident.
- 22. Department where event or exposure occurred** - Indicate exact location where event or exposure occurred.
- 23. Other workers injured or ill in this event?** - Enter "Yes" or "No."
- 24. Equipment, materials, and chemicals the employee was using when event or exposure occurred** - Provide specific information about the object or substance that directly injured the employee.
- 25. Specific activity the employee was performing when event or exposure occurred** - Describe briefly what employee was doing when accident occurred.
- 26. How injury or illness occurred. Describe sequence of events. Specify object or exposure that directly produced the injury/ illness** - Provide pertinent details regarding the accident. Be specific. If the accident involved a motor vehicle and a police report was taken, a copy of the report will need to be provided once it is received.
- 27. Name and address of physician** - Enter the name and address of physician who treated the employee at the time of injury. If a physician did not see the employee, leave blank.
- 27a. Phone Number** – Provide the treating physician's phone number.
- 28. Hospitalized as an inpatient overnight? If Yes, then, Name and address of hospital** - If applicable, enter the name and address of the hospital.
- 28a. Phone Number** – Provide the phone number of the hospital.
- 29. Employee treated in Emergency Room?** - Check "Yes" or "No."

#### **Employee Section**

- 30. Employee name** - Enter employee's full legal name.
- 31. Social Security Number** – Enter employee's social security number.



32. **Date of Birth** – Enter employee’s date of birth as mm/dd/yy.
33. **Home address** – Enter employee’s home address.
- 33a. **Phone number** – Enter employee’s HOME phone number.
34. **Sex** – Check “Male” or “Female”
35. **Occupation/CBID#** - Enter employee's regular job title and Civil Service Classification, and CBID# (Collective Bargaining Identification Number) as shown on attendance report.
36. **Date of hire** - Enter date employee first appointed at department.
37. **Employee usually works** - Enter employee's normal work schedule.
- 37a. **Employment status** - Enter employee's "current" employment status. If employee has separated from State Service or has transferred to another agency, check "Other" and indicate status.
- 37b. **Under what class code of your policy were wages assigned?** -  
LEAVE BLANK.
38. **Gross wages/salary** - Enter employee's monthly salary rate. For intermittent employees, enter the hourly rate.
39. **Other payments not reported as wages/salary** – Check “Yes” or “No” – Most will be “No.”
40. **Public Employees’ Retirement System (PERS) or State Teachers’ Retirement System (STRS) members** - Check “Yes” if employee is a member. Please note; Alternate Retirement Benefit (ARB) participants are considered PERS members.
41. **CSID#** - Enter employee’s complete position number; 3 digit division, 4 digit position or job classification, 3 digit serial number.

**Completed by** – Print or type name of person completing this form.

**Signature & Title** – Person completing form should provide their title, sign and date.

Use the attached cover sheet to fax the completed e3067 and e3301 (if immediately available) to the State Fund Customer Service Center (CSC) within 5 days of employer’s knowledge. Be sure to indicate which State Fund office should adjust the claim. The CSC will send the claim number to the e-mail address provided on the cover sheet.

## **Reverse side of the 3067**

As noted on the form, do not delay submission of this report to wait for completion of the reverse side. While this side may contain useful information for your department, IT IS NOT NECESSARY TO ESTABLISH THE CLAIM. Opinions about the injury or employee can be relayed directly to the assigned adjuster separately.

### **Supervisor's Review**

The person who conducted the investigation needs to complete this section.

Enter injured employee's name, unit and Social Security number.

**Check one of the three boxes** - This is the investigating person's opinion of whether the injury is clearly work related or needs to be investigated further.

**Give the facts that justify the items checked** - Provide concise information in this space to justify your opinion. You may provide this information on a separate memo to State Fund.

**What corrective action is being taken to prevent similar accidents? Have you taken these steps?** - Indicate in the space provided any corrective action to be taken to prevent similar accidents and whether the action has been taken.

**I do not have authority to take the following action but recommend** - If the action recommended is not within the person's authority to accomplish, enter comments in the space provided.

**If injured employee is unable to perform full duty** - If the employee cannot continue working in their normal position, indicate what steps have been made to find modified duty.

**Signature, Classification and Date** – Person completing this review should provide their title (classification), sign and date.

### **Manager's Review**

**Do you concur with first-line supervisor's review?** – If no, explain.

**Signature and date** – Person completing the second review should sign and date.

The department is responsible for preserving all evidence related to the injury or illness (furniture, equipment). If evidence cannot be preserved (wet floors, loose tiles), arrangements should be made to have the scene photographed. If you have any questions about documenting the accident, please contact your Return to Work Coordinator.

**ACKNOWLEDGEMENT OF RECEIPT OF THE WORKERS' COMPENSATION CLAIM FORM (DWC 1) & NOTICE OF POTENTIAL ELIGIBILITY (e3301)**

To (Employee): \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Date Claim Form Provided or Sent First Class Mail to Employee: \_\_\_\_\_

Attached is a *Workers' Compensation Claim Form & Notice of Potential Eligibility* (e3301). Your employer is required to provide this form to you within one working day of receiving notification of a potential work related injury or illness.

Please read the form carefully to understand your rights. Complete the claim form if you want to pursue a claim for a work-related injury or illness. Your insurance carrier is State Compensation Insurance Fund (State Fund). State Fund is responsible for making all liability determinations regarding your claim. State Fund determines liability using available medical documentation and relevant facts.

**EMPLOYEES ACKNOWLEDGEMENT OF RECEIPT**

This is to acknowledge that I have received a *Workers' Compensation Claim Form & Notice of Potential Eligibility* (e3301).

I understand that if I want to pursue a claim for a work related injury or illness, it is my responsibility to complete the form and return it to my employer.

Date Claim Form Received: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

**EMPLOYER'S CERTIFICATION**

Date Claim Form Provided to Employee or Sent First Class Mail: \_\_\_\_\_

Name and Title of Employer Representative: \_\_\_\_\_

Signature and Date: \_\_\_\_\_

**WITNESS CONTACT SHEET**

This sheet can be completed at the same time as the Employers' Report of Injury (e 3067). This information will be sent to the State Fund adjuster assigned to this claim. If you have questions, please see your Return to Work Coordinator.

Employee: \_\_\_\_\_

Date of Injury or Illness: \_\_\_\_\_

Employee's Work Location: \_\_\_\_\_

**WITNESSES, POTENTIAL WITNESSES, AND KNOWLEDGEABLE PERSONS**

The people listed below have been identified as having knowledge about the claimed work-related injury or illness. The people listed may be asked to make a statement or provide testimony surrounding the facts of the claim before the Workers' Compensation Appeals Board.

Return To Work Coordinator: \_\_\_\_\_

Personnel Services Specialist : \_\_\_\_\_

Timekeeper: \_\_\_\_\_

1<sup>st</sup> Line Supervisor: \_\_\_\_\_

2<sup>nd</sup> Line Supervisor: \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Witness : \_\_\_\_\_

Completed by: \_\_\_\_\_

Title and Date: \_\_\_\_\_

**FAX COVER SHEET for a New State Contract Services Claim**

**TO: State Fund Customer Service Center**

**FAX: 800-371-5905**

**Date:** \_\_\_\_\_ **Total # of pages:** \_\_\_\_\_

**From:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Agency Name:** \_\_\_\_\_

**Agency Number:** \_\_\_\_\_

**GRPNUM: STATES**

Attached please find:

XX 3067 Employer's First Report of Injury (MANDATORY)

\_\_\_\_ 3301 Employee Claim Form (if available)

Injured workers' name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Please forward to (check one only):

\_\_\_\_ TL Sacramento

\_\_\_\_ TN Santa Ana

\_\_\_\_ TQ Riverside

\_\_\_\_ TY Rohnert Park

\_\_\_\_ TY Eureka

E Mail address to send claim number: \_\_\_\_\_

**Instructions to Agency.** This fax MUST include the 3067. Please include the 3301 if you have it at the same time, do not send the 3301 separately from the 3067 to the CSC. Only one Fax to the CSC per claim and only one claim per Fax. Do not fax multiple 3067s for different claims in the same fax transmission; each new claim must be faxed separately. Once you receive the claim number back from the CSC via e-mail, please FAX the additional documents to the adjuster's direct FAX number.

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