Instructions: The staff member that distributes this packet to the employee must review these forms with the injured employee within 1 working day of notification of injury and check off that each form was included and completed as directed. Return this sheet with other items to the D.O. for claim submission.

Workers' Compensation Packet
Check List

Form Name	Completed By	Instructions	Completed (✓)
Covered Employee Notification of Rights Material (6 pages)	N/A	Distribute to employee as reference material (English or Spanish).	☐
Employee Questionnaire (1 page)	Employee	Employee completes form and returns to supervisor for submission to D.O. This should be completed even if the employee does not wish to file a workers' compensation claim.	☐
WC Temporary Prescription Card (2 pages)	Supervisor	Supervisor completes form and distributes to employee for use if medication is prescribed by WC physician.	☐
Treatment Referral Form (1 page)	Supervisor	If medical treatment is needed and employee does NOT have a pre-designated physician, then supervisor completes the appropriate referral form and gives to employee for treatment at Kaiser On-The-Job or other medical provider.	☐
Supervisor's Report of Employee Injury (1 page)	Supervisor	Supervisor completes and returns to D.O.	☐
DWC 1 – Not Online (4 pages)	Supervisor/ Employee	Employee completes top portion and supervisor completes bottom portion of form (skip #14 and #15). Give pink copy to employee and return remaining 3 pages to D.O.	☐
Employer's Report of Occupational Injury or Illness (5020) – Not Online (3 pages)	Supervisor/ Employee	Supervisor and employee complete form together and send to D.O. Supervisor signs at the bottom.	☐
Clinic Evaluation Survey (1 page)	Employee	If employee seeks treatment from one of our medical providers, they must complete this survey regarding their first or second visit to the medical facility.	☐

Injured Employee: By signing this form, I agree that I was provided with all of the appropriate forms and was given the option to be treated for my injury at the time I notified my supervisor. I understand that if I do NOT have a pre-designated physician on file with Human Resources, I must be treated by a covered medical provider in order for my medical treatment to be covered under my workers' compensation claim.

Printed Name/Signature of Staff Member Distributing Packet: _____ Date Distributed: _____

Printed Name/Signature of Injured Employee: _____ Date of Injury: _____