REPORTING ONLY/FIRST AID FORM

CITY OF OXNARD CALIFORNIA

This form is to be used to document **Reporting Only (non-injury incidents) and First Aid Accidents Only**.

DO NOT USE THIS FORM WHEN IT INVOLVES NEEDLE STICKS, BLOODBORNE PATHOGENS OR OTHER INFECTIOUS AGENTS.

Non-Injury incidents are those that do not result in an injury or need for any medical care for the employee. **First Aid** accidents are those in which the employee receives only minor first aid such as a band-aid for minor scratches and cuts; an ice pack for a bruise; etc., and also do not ordinarily require medical care.

The reason an employee may want to complete this form would be to notify the City of the occurrence in case there is an issue in the future. In the above cases, employees and supervisors may complete this form in lieu of completing the injury packet. **However, employee will receive the full packet if they decide to file a claim in the future based on this reporting only incident or first aid accident.**

I have been informed of the "Workers' Compensation Injury Report Packet" for the City of Oxnard including the Workers' Compensation Claim Form DWC-1. I have elected to complete the Reporting Only/First Aid Form. I understand that if in the future I choose to file a claim, I will be required to notify my supervisor and complete the Worker's Compensation Injury Report Packet which includes the following:

By my signature, I hereby acknowledge that I have been advised by my supervisor regarding the DWC-1 Form.

If medical care is subsequently required, I will contact my supervisor and we will refer to the reporting requirements and complete all paperwork in the Workers' Compensation Injury Report Packet. Then immediately forward the completed packet to Workers' Compensation for processing. **Please be sure to attach the Reporting Only/First Aid Form.**

Description of Incident/Accident (To be completed by employee):

_____

_____

_____

Date of Incident/Accident (Required) and Time of Day: _____

Name: _____ Birth Date: _____

Home Address: _____ Home Phone: _____

City and Zip: _____ Work Phone: _____

Department: _____ Job Title: _____

Print Employee's Name	**Employee's Signature**	**Date**

Signature of City's Representative Supplying Form to Employee	**Date**	**Telephone #**

Employee please make a copy and keep for your records.

For Internal Workers' Comp Use Only

_____

Received by:

_____

Received Date and Time: