Santa Cruz County Fire Agencies
Insurance Group

RECEIPT

RECEIPT OF WORKER'S COMPENSATION CLAIM FORM (DWC-1)

Supervisor and employee complete this form IF employee declines to complete/file DWC-1 Form
Ensure that the employee retains the DWC-1 Form

Employee's Name (print) _____

Fire District _____

Injury Occurred **Date:** _____ **Time:** _____

Nature of Injury _____

Place Injury Occurred _____

Employee Reported Injury **Date:** _____ **Time:** _____

Claim Form (DWC-1) Offered to Employee **Date:** _____ **Time:** _____

Employee's Signature _____

Supervisor Completing Form (print) **Name:** _____

Date: _____ **Time:** _____