ACKNOWLEDGEMENT OF RECEIPT
of
Employee Claim Form

I acknowledge receipt of an Employee's Claim for Workers' Compensation Benefits (Form DWC-1).

This information was received:

From: ____
(Manager, Supervisor or Lead Person)

District Name: ____

On: ____________________ At:________________
(Date) (Time)

___________________________ ___________________________
Employer Signature Employee Signature

___________________________ ___________________________
Date Date

Note: If you need treatment for this incident later, bring your copy of the DWC-1 to the District Office representative and to your Supervisor or Principal. The District Office will authorize an Urgent Care visit to the SIG-Designated Occupational Health Clinic most convenient to you.