GOLDEN RAIN FOUNDATION
INCIDENT/ACCIDENT REPORT CHECKLIST

REPORTED BY:	**DATE OF REPORT:**
REPORTED TO:	**DATE OF ACCIDENT:**

Accidents must be reported IMMEDIATELY. When completing the checklist all boxes must be checked.

ACCIDENT REPORT CHECKLIST

- ☐ Contact Public Safety / Securitas at (925) 988-7863
- ☐ Contact Your Manager/or HR at (925) 988-7615
- ☐ Partner with your Manager / HR to complete Incident/Accident Report, Vehicle Information (Pages 1 & 2)

NON-INJURY

- ☐ Was employee injured? ____ Yes ____ No

If YES, move on to INJURY.

- ☐ Employee was not injured (skip page 4, skip page 5 move on to next step).
- ☐ Ensure above steps and documentation completed
- ☐ ***SEE Your Manager / HR.***

INJURY

If life threatening emergency call 911

- ☐ Partner with your Manager or HR to call Company Nurse
- ☐ Does your injury require medical treatment?__Yes__No (If no, move on to next step)
- ☐ Complete Incident Report, Vehicle & Witness Info
- ☐ Complete State of CA Workers' Compensation Form

OFFICE USE ONLY

NOTES: _____

_____

_____

_____

_____

INCIDENT/ACCIDENT REPORT

Name of Employee Completing Report: _____

Name of Employee Involved: _____

Employee Telephone Number: _____

ACCIDENT INFORMATION

Accident Date: _____

Public Safety Notified: _____ Police at Scene: _____

Photos Taken: _____ Police Case Number: _____

Location Where Accident Occurred: _____

_____

Description of Incident, Accident, Vehicle and Property Damage: _____

_____

_____

_____

_____

_____

_____

_____

VEHICLE INFORMATION

Vehicle Driver:_____ **GRF Vehicle ID Number:** _____

Vehicle License Number:_____ **Year/Make:** _____

Other Vehicle Information

Vehicle Driver:_____ **GRF Vehicle ID Number:** _____

Vehicle License Number:_____ **Year/Make:** _____

Witnesses of Incident/Accident

Name:_____

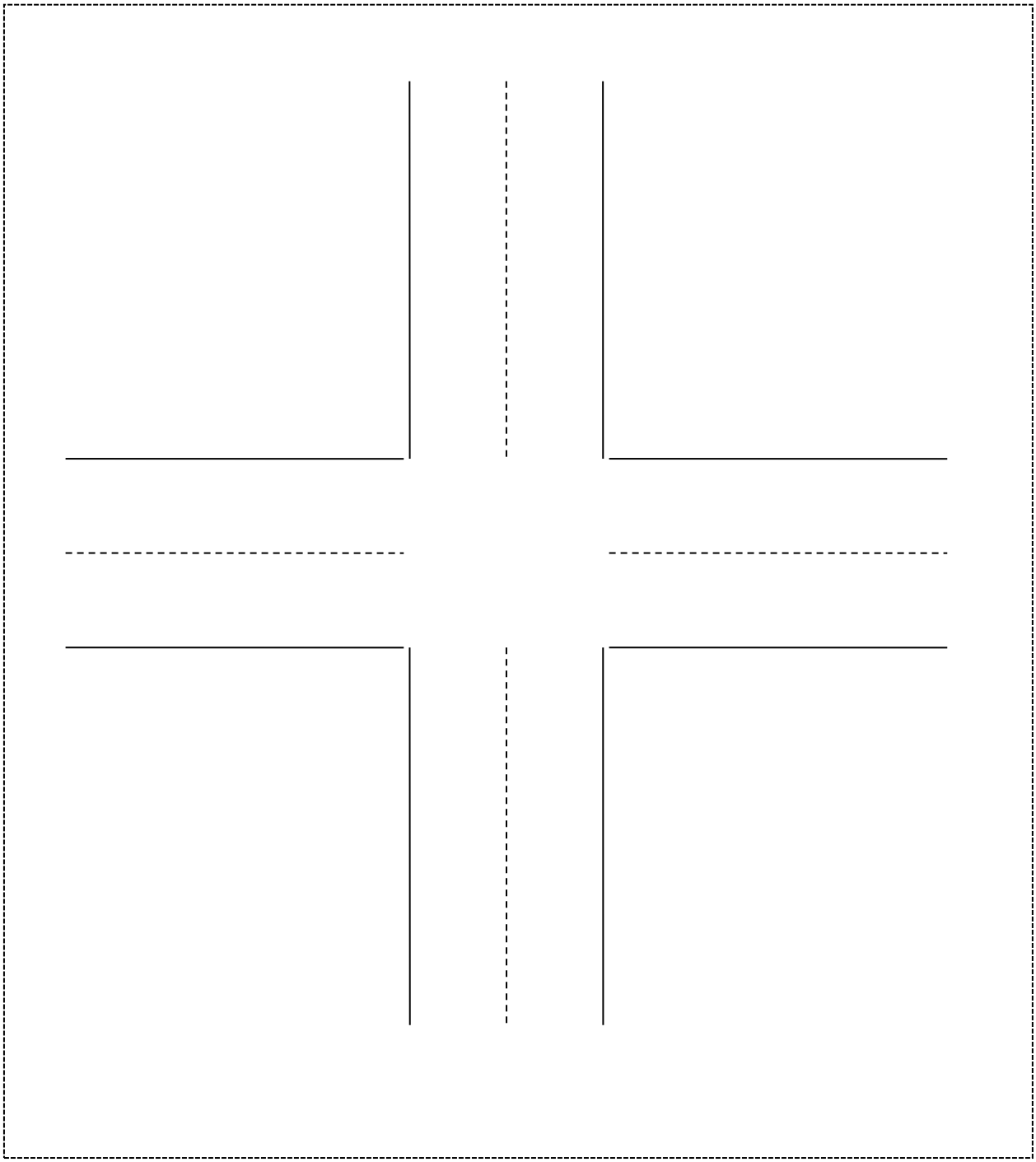
Telephone: _____

Signature of *Person* Reporting:_____ Date: _____

Signature of *Individual* Involved:_____ Date: _____

Signature of *Witness* Reporting:_____ Date: _____

INCIDENT/ACCIDENT REPORT DIAGRAM



Attach second sheet if needed for additional information.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado*. _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* **Golden Rain Foundation**
11. Address. *Dirección.* **800 Rockview Drive, Walnut Creek, CA 94595**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros*. **Everest Insurance Company, Sedgwick, PO Box 14442, Lexington, KY 40512-4442**
16. Insurance Policy Number. *El número de la póliza de Seguro.* **CA10002588201**
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* **HR Generalist II** 19. Telephone. *Teléfono.* **(925) 988-7610**

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐Employer copy/*Copia del Empleador* ☐Employee copy/*Copia del Empleado* ☐Claims Administrator/*Administrador de Reclamos* ☐Temporary Receipt/*Recibo del Empleado*

If not going to Concentra: Physician Name / Address/ Phone:

- Our carrier:

Everest Insurance Company
Sedgwick
PO Box 14442
Lexington, KY 40512-4442 Phone
800 723 2505
Policy Number:
CA10002588201

Golden Rain Foundation
800 Rockview Drive, Walnut Creek, CA
Phone Number 925-988-7615
State Unemployment Number
189-9138 Property Mgmt. / Private Employer

Work Related Injury or Illness during working hours (8:00-5:00pm), send employee To: Concentra
1981 N. Broadway Avenue. Suite 190
Walnut Creek, CA 94596
(925) 932-7715
Emergency and After Hours, send employee to;
Kaiser Medical Center- Walnut Creek
1425 S. Main Street, Walnut Creek, CA 94596
925-295-4070

EMPLOYEE REFUSAL OF MEDICAL TREATMENT

This form is to be filled out by any employee who refuses medical treatment for an on-the-job injury.

I, _____, have been offered medical attention
(print name)

for the following injury and refused to go to the doctor.

The incident occurred on _____
(date)

Description of the injury:

_____

_____

_____

How did the injury occur?

_____

_____

_____

I understand that if I choose to have medical treatment in connection with this incident, I must contact my employer immediately for the name and address of the clinic that is authorized to treat me. I understand that my employer will not pay for any unauthorized medical services that I might incur.

_____ _____
Employee Signature Date

_____ _____
Supervisor Date