



**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: _____ (Date) At: _____ (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.