



**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.