



NORTH ORANGE COUNTY
COMMUNITY COLLEGE DISTRICT

Workers' Compensation Information and Forms Distribution Confirmation

Employee's name (please print)	
College/Department	
Date of injury:	
Date of Notice of Injury from employee	

Forms provided:

- **Information about WC Claim Process**
- **Employee's Account of Injury Form**
- **DWC-1 (Claim) Form**
- **Choosing Medical Care for Work-Related Injuries and Illnesses**
- **Mitchell First-Fill Temporary Prescription Card**

I confirm receipt of the paperwork listed on this form, in the event I choose to pursue District's Workers' Compensation benefits. I understand that even if I don't require a medical care or file a claim, I must complete the Employee's Report of Injury/Illness form within three days after the injury and submit it to my manager.

Employee's signature

Signature of employer's representative/Supervisor

Name of employer's representative (please print)

Date

Date