ment of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

EMPLOYEE:

1. Name Donald Mendinger Today's Date 9/4/90
2. Home Address /
3. City _____ State _____ Zip _____
4. Date of Injury 9/4/90 Time of Injury 1:30 ____ a.m. ✓ p.m.
5. Address/Place where injury happened Nancy Dutton prop - Henryrd .
6. Describe injury and part of body affected fell in 3 ft. hole with left leg - fell on left knee .
7. Signature of employee Donald Mendinger

EMPLOYER: *COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.*

8. Name and address of employer SAN JOAQUIN COUNTY MOSQUITO ABATEMENT DIST.
   5503 South Airport Way
   Stockton, California 95206
9. Date employer first knew of injury 9/4/90
10. Date claim form was provided to employee 9/4/90
11. Date employer received claim form 9/4/90
12. Name and address of insurance carrier or adjusting agency Keenan & Associates
    1760 Creekside Oaks Drive #220 Sacramento CA 95833
13. Signature of Employer Representative Carl Ahstrand
14. Title Secretary 15. Telephone 209 932-4675

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

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

DWC Form 1 (1/1/90)

INSURER/CLAIMS ADMINISTRATOR COPY