## LOG FOR DISPENSING "EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS" FORM DO NOT DISPENSE FOR FIRST AID ONLY CLAIMS (DWC-1)

INJURED'S NAME	INJURY DATE TIME		INJURY REPORTED TO:	INJUY	IF EMPLOYEE IS GIVEN A CLAIM FORM:	
		E INJURY TYPE:		REPORTED: DATE TIME	DATE TIME	SIGNATURE CONFIRMING RECEIPT OF COMPLETED DWC-1 FORM:
Employee	01/01/01 12:30	pm Right Thumb (Detailed Description)	Supervisor/Dept HR/Safety Rep	01/01/01 1:30pm	01/01/01 2:30pm	Supervisor/Department HR/Safety Rep
		elaim form is given to en supervisor or distributor	nployee: will be required to fill out the	e following informa	tion in <b>RED</b>	
	abov	2.	must sign last column once th			
	signe	d/completed DWC-1 cla e see below for blank co	aim form.	1 5		
			F.).			

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