



## **WORKERS' COMPENSATION INJURY REPORT PACKET FOR THE CITY OF OXNARD**

**PLEASE FOLLOW THE INSTRUCTIONS BELOW TO REPORT A JOB-RELATED INJURY**

- 1. COMPLETE the Report of Occupational Injury or Illness (CA Form 5020)**  
To be completed/signed by Supervisor or Manager
- 2. COMPLETE the Employee's Claim of Workers' Compensation Benefits (CA Form DWC-1)**  
Employee: Complete "Employee" section and give the form to your Supervisor. Supervisor: Once the Employee completes the top section and returns the form, complete the bottom "Employer" section. It is very important that all dates required be completed. Once the form is completed, provide a copy to the employee. This should take place within one working day of the injury.
- 3. COMPLETE the Body Diagram**  
To be completed/signed by Employee.
- 4. COMPLETE Supervisor's Incident Investigation Report**  
The be completed/signed by the Supervisor or Manager
- 5. COMPLETE the Physician's Notice of Return to Work/Temporary Medical Restrictions**  
This form is to be given to the Employee, who should take this form to the medical facility to be completed by the medical provider. The injured Employee is responsible for returning the completed form to the Supervisor and/or Human Resources for forwarding to CorVel.
- 6. COMPLETE the Temporary Modified Duty Agreement**  
If the Employee is prescribed work restrictions by the medical provider due to the work injury, the Employee and Supervisor should meet with Human Resources staff to review and sign the Temporary Modified Duty (TMD) Agreement prior to the employee being accommodated with a modified duty assignment.
- 7. PROVIDE Notice of Workers' Compensation Benefits**  
Employee can choose one of the listed preferred medical providers.
- 8. PROVIDE First Fill Prescription Form**  
This form is an instant access card for the initial (first) prescription fill.
- 9. OPTIONAL Voluntary Pre-Designation Form**  
To treat with your personal physician for a work related injury, a completed/signed Predesignation of Personal Physician form must be on file prior to the date of injury.
- 10. SCAN all completed forms, in color, to CorVel and Risk Management Staff:**  
Via email: [FNOL\\_FAX@CorVel.com](mailto:FNOL_FAX@CorVel.com), [mike.more@oxnard.org](mailto:mike.more@oxnard.org), [alex.juarez-pina@oxnard.org](mailto:alex.juarez-pina@oxnard.org), and [john.hanes@oxnard.org](mailto:john.hanes@oxnard.org). Or report injury by calling: 855.429.7199

**NOTICE: ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.**