ACKNOWLEDGEMENT OF RECEIPT OF A WORKERS' COMPENSATION CLAIM FORM (DWC 1) & NOTICE OF POTENTIAL ELIGIBILITY (e3301)

To (Employee): _____

Date of Injury: _____

Date Claim Form Provided or Sent First Class Mail to Employee: _____

Attached is a *Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility* (e3301). Your employer is required to provide this form to you within one working day of receiving notification of a potential work-related injury or illness.

Please read the form carefully to understand your rights. Complete the claim form if you want to pursue a claim for a work-related injury or illness. Your insurance carrier is State Compensation Insurance Fund (State Fund). State Fund is responsible for making all liability determinations regarding your claim. State Fund determines liability using available medical documentation and relevant facts.

EMPLOYEE'S ACKNOWLEDGEMENT OF RECEIPT

This is to acknowledge that I have received a *Workers' Compensation Claim Form* (DWC 1) *& Notice of Potential Eligibility* (e3301).

I understand that if I want to pursue a claim for a work-related injury or illness, it is my responsibility to complete the form and return it to my employer.

Date Claim Form Received: _____

Employee Signature: _____

EMPLOYER'S CERTIFICATION

Date Claim Form Provided to Employee or Sent First Class Mail: _____

Name and Title of Employer Representative: _____

Signature and Date: _____