

Monterey County
Injury/Illness Report

Check If	NOTICE ONLY
	First Aid Only/No Time Lost DO NOT CALL Liberty

Department Contact: _____

SECTION I - Completed by: SUPERVISOR

Date of Injury _____ Time of Injury _____ SSN: _____

Employee Name:(last) _____ (first) _____ DOB: _____

Location of Injury: _____ (Street/City/State/Zip)

Location Code: (_____)Policy Number: WP8-66B-004150-044 Policy/Contract Type: Liberty Mutual

Employee/Claimant Information

Address _____ City _____ State CA Zip _____
(Employee's Home)

Phone: (_____) _____ Marital Status _____ Sex: M / F (circle one)

Occupation/Job Title _____ Department Name: _____ Date Hired: _____

Hourly Wage \$ _____ Average Weekly Wage: \$ _____ Education Level: UNKNOWN

Hours Worked/Week _____ Days Worked/Week _____ Hours Worked/Day _____

Employment status: _____ Salary continuation? NO Paid for Day of Injury? yes ___ no ___

Treating Physician/Medical Facility _____ County Authorized Facility? yes ___ no ___
(name, address, & phone) Designated Physician? Yes ___ No ___ (see list on back)

Injury/Illness Description

Accident Description: _____

Safeguards Provided: _____ Safeguards Utilized: _____

Anyone Else Injured: _____ Witness(es): _____ Phone Number/Ext: _____

Time work day began for _____ Date _____
employee on Injury Date: _____ reported _____ Specific part of body injured: _____
(Right/Left, Upper/Lower)

Description of injury: _____

Lost work days? yes ___ no ___ If yes, first full day disabled: _____ Date last worked: _____

Date Disability Began: _____ Date Estimated Return to Work: _____ (or) Date Returned: _____

Claim/Authorization Number _____ (PLEASE FILL IN. Provided to you by LM Intake Personnel)

Date Claim Form/DWC provided to employee _____ Type of Employer: County Government

SECTION II - Completed by: EMPLOYEE

(For the purpose of training development) Does the employee feel that the injury was preventable? yes ___ no ___
If yes/suggestions for prevention: _____

(Employee statement: By my signature below, I certify that all the information provided above in this report is true and correct.)

Employee signature: _____ Date: _____

(OVER)

SECTION III - Completed by: SUPERVISOR

Primary Cause/Contributing: _____

What act(s) contributed to the incident? (twisting, bending, reaching etc) _____

Does the supervisor feel that the injury was preventable? Yes ____ No ____

If yes, suggestions for prevention: _____

What immediate corrective action will be taken to prevent a recurrence? (counseling, training etc.) _____

Supervisor completing injury form (*print*) _____ Phone: (831) _____

Supervisor signature: _____ Date: _____

CALL LIBERTY MUTUAL INTAKE AT: 1-800-362-0000

**County of Monterey
Authorized Treatment Facilities**

The employee's "Claim Number" is the authorization number for treatment at the County Authorized Treatment Facility. Authorized facilities are listed below:

Salinas Area

Non-Emergency Care:

*Natividad Medical Center
Occupational Medicine Dept.
1441 Constitution Road
Salinas, CA
(831) 755-5530
Mon.-Fri. 8:00 a.m.- 5:00 p.m.*

Emergency Care:

*Natividad Medical Center
1441 Constitution Road
Salinas, CA
(831) 755-4111*

Monterey Area

Non-Emergency Care:

*Doctors on Duty
389 Lighthouse Avenue
Monterey, CA
(831) 649-0770
Mon. – Sun. 8:00 a.m.-8:00 p.m.*

Emergency Care:

*Community Hospital of the Monterey Peninsula
23625 Holman Highway
Monterey, CA
(831) 624-5311*

*Doctors on Duty
Monterey-Fremont Clinic (Includes PT)
2260 North Fremont
Monterey, CA
(831) 883-3330*

Mon. – Fri. 8:00 a.m.-6:00 p.m. Sat. – Sun. 8:00 a.m.- 8:00 p.m.

South County Area

Non-Emergency Care:

*Southern Monterey Co. Medical Group
210 Canal Street
King City, CA
(831) 385-5471*

Emergency Care:

*George Mee Memorial Hospital
300 Canal Street
King City, CA
(831) 385-6000*

*Doctors on Duty
Greenfield Urgent Care
634 Walnut Ave., Greenfield, CA
(831) 674-3255 Mon.-Fri. 8:00 a.m.-8:00 p.m.*

*Twin Cities Community Hospital
1100 Las Tablas Road
Templton, CA
(805) 434-3500*

Sat. 9:00 a.m. – 6:00 p.m., Sun. 9:00 a.m. – 3:00 p.m.