EMPLOYEE'S CLAIM FOR WORKERS' INJURY BENEFITS	*PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR*
If you are injured or become ill because of your job, you may be entitled to workers' injury benefits. Please complete this form and submit it to your employer.	*Si usted se lesiona o se enferma debido a su trabajo, pudiera tener derecho a recibir beneficios de compensación al trabajador.*

NOTICE: Indian Reservations are sovereign nations and are not subject to State or Federal Workers' Compensation laws. By completion of this form you are submitting to the sole jurisdiction of the Tribe.

AVISO: Las Reservaciones Indígenas son naciones soberanas y no están sujetas a als Leyes Federales y Estatales de Compensación al Trabajador. Al completar esta forma, usted se está sometiendo a la jurisdicción exclusiva de la Tribu y del Tribunal Indíjena.

Employee: *Empleado:*

1. Name. *Nombre.* ________ Today's Date. *Feche de Hoy.* ________
2. Home Address. *Direccion Residential.* ________
3. City. *Cuidad.* ________ State. *Estado.* ________ Zip. *Código Postal* ________
4. Date of injury. *Feche de la lesion (accidente).* ________ Time of Injury. *Hora en que occurrió.* ____ *a.m.* ____ *p.m.*
5. Address and description of where injury happened. *Dereccion/lugar dónde occurrió el accidente.* ________
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectado.* ________
7. Social Security Number. *Numeró de Seguro Social del Empleado.* ________
8. Signature of employee. *Firma del empleado.* ________

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleador como recibo.

9. Name of employer. *Nombre del empleador.* ________
10. Address. *Dereccción.* ________
11. Date employer first knew of injury. *Feche en que empleador supo por primera vez de la lesión o accidente.* ________
12. Date claim form was provided to employee. *Feche en que el se le entregó al empleado la petición.* ________
13. Date employer received claim form. *Feche en que el empleado devolvió la peticion al empleador.* ________
14. Name of insurance carrier or adjusting agent. *Nombre de la compañia de seguros o agencia.*
    TRIBAL FIRST CLAIMS MANAGEMENT
15. Insurance Policy Number. *El numero de la póliza del Seguro.* ________
16. Signature of employer representative. *Firma del representate del empleador.* ________
17. Title. *Titulo* ________ 18. Telephone. *Teléfono* ________

Employer: Date this form and provide copies to TRIBAL FIRST CLAIMS ADMINISTRATION and the employee, dependent or representative who filed the claim.	***Empleador:*** *Feche esta forma y proporcione copias a TRIBAL FIRST CLAIMS ADMINISTRATION y al empleado, dependiente o representante que haya presentado esta peticion*

HOOPA VALLEY TRIBAL COUNCIL
(WORKERS COMPENSATION PROGRAM)
REFERRAL FOR MEDICAL CARE

DATE:____________________

NAME OF EMPLOYEE:____

DEPARTMENT/ENTITY:____

M.D. TO WHOM EMPLOYEE IS REFERRED:___________________________________

REFERRAL BY EMPLOYEE SUPERVISOR/REPRESENTATIVE:______________________

____

SIGNATURE OF EMPLOYEE/SUPERVISOR REPRESENTATIVE:______________

____

____

PLEASE COMPLETE AND RETURN LOWER HALF OF FORM

____

TO EMPLOYER: HOOPA VALLEY TRIBAL COUNCIL-DIVISION/ENTITY:

____

(INSERT NAME OF TRIBAL DEPARTMENT,DIVISION AND/OR ENTITY)

NAME OF EMPLOYEE:____

DATE EMPLOYEE UNDERWENT TREATMENT:________________________________

DIAGNOSIS:____

TREATMENT RENDERED:____

____

REMARKS BY M.D.____

____

MAY RETURN TO WORK:______________________LIMITATIONS:____________

____

[ ] Regular [ ] Limited COMMENTS:________________________

CARE TO BE RENDERED OR ADDITIONAL INSTRUCTIONS:______________________

____

DATE OF APPOINTMENT FOR FURTHER TREATMENT:__________________

MAY NOT RETURN TO WORK UNTIL THE DATE SPECIFIED:______________

____

SIGNATURE OF MEDICAL DOCTOR:_______________________________________

NOTICE TO DOCTOR: PLEASE FORWARD YOUR FIRST REPORT TO

TRIBAL FIRST CLAIMS ADMINISTRATION•P.O. BOX 609015•SAN DIEGO, CA 92160

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST CLAIMS ADMINISTRATION

P.O. Box 609015
San Diego, CA 92160
FAX: (858) 277-4519

☐ Fatality

EMPLOYER

1. FIRM NAME
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, Zip)
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY ______

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm dd yy)
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
13. DATE OF HIRE (mm dd yy)
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury) ____ regular full time ____ part-time ____ temporary ____ seasonal
14B. DEPARTMENT CODE
15. GROSS WAGES SALARY $______ per ______
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging overtime, bonuses, etc.)? ☐ YES, $ ______ per ______ ☐ NO

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy)
18. TIME INJURY/ILLNESS OCCURRED ____ A.M. ____ P.M.
19. TIME EMPLOYEE BEGAN WORK ____ A.M. ____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm dd yy)
23. DATE RETURNED TO WORK (mm dd yy)
24. IF STILL OFF WORK, CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm dd yy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy)
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck
35. HOW INJURY/ILLNESS OCCURRED, DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

DO NOT USE THIS COLUMN

Case No.
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per week
Weekly hours
Weekly wage
County
Nature of injury
Part of body
Source
Event
Sec. Source
Extent of injury

Completed by (type or print)	Signature	Title	Date

TF-107 (12/99)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY