TAFTCOLLEGE
WEST KERN COMMUNITY COLLEGE DISTRICT

ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION CLAIM FORM (DWC 1)

DATE OF INJURY: _____

DATE OF EMPLOYER KNOWLEDGE: _____

I, _____, hereby acknowledge that I received the Workers' Compensation Claim Form (DWC 1) and the MPN handbook from Taft College on _____, and I am ❑ requesting ❑ denying medical care.

_____ _____
Team Member Signature Date

_____ _____
Supervisor Signature Date