



**Kern County Sheriff's Office**  
**Policies and Procedures**

TITLE: EMPLOYEE'S CLAIM FOR WORKER'S BENEFITS FORM		NO: N-230	
APPROVED: Donny Youngblood, Sheriff-Coroner			
EFFECTIVE: September 15, 1993	REVIEWED: 11/20/2025	REVISED: 11/20/2025	UPDATED: 11/20/2025

**POLICY**

The State of California *Workers' Compensation Claim Form (DWC 1)* must be given to any employee who seeks medical treatment beyond first aid or has lost time beyond the date of injury. The form must be provided to the employee in person or by mail within 24 hours of the employer learning from any source of the injury/illness that resulted in medical treatment beyond first aid or lost time beyond the date of injury.

Attached is a copy of a State of California *Workers' Compensation Claim Form (DWC 1)* (Rev. 1/1/2016). The following guidelines will be used to complete the form:

**“EMPLOYEE” Section, completed by injured or ill employee:**

LINE #

1. List the name of the employee submitting the claim and the current date.
2. List the home address of the employee submitting the claim.
3. List the city, state and zip code of the employee submitting the claim.
4. List the date and time the injury occurred.
5. List the address or describe the place where the injury occurred.
6. Describe the injury and the part of the body affected. Be specific.
7. List the Social Security number of the employee submitting the claim.
8. Check box if employee agrees to receive notices by email only.
9. Signature of the employee submitting the claim.

**“EMPLOYER” Section, completed by the supervisor:**

LINE #

10. This space should read “County of Kern”.
11. This space should read “1115 Truxtun Avenue, Bakersfield, CA 93301”.
12. List the date the Sheriff's Office first learned of the employee's injury.

13. List the date the form was provided to the employee.
14. List the date the form was received by the Sheriff's Office with the employee's section completed.
15. This space should read, "County of Kern - Risk Management 1115 Truxtun Avenue, 4th Floor, Bakersfield, CA 93301 (661) 868-3801".
16. Should read, "Self-insured."
17. Signature of the supervisor receiving the form.
18. List the title of the supervisor signing the form.
19. List the phone number of the supervisor signing the form.

End of form.

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