



# NEW CLAIM ADDITIONAL INFORMATION REQUIRED FAX

DATE : \_\_\_\_\_

TO : CCCSIG

FAX : 925.692.1137

FROM \_\_\_\_\_ District  
\_\_\_\_\_ Claims Coordinator

SUBJECT : ADDITIONAL INFORMATION REQUIRED  
\_\_\_\_\_ CLAIMANT

Additional information required to complete the Claim Reporting process:

Time of Injury \_\_\_\_\_

Employment Type (check one) Full Time:  10 mos  11 mos  12 mos  
Part Time:  10 mos  11 mos  12 mos  
 Substitute  Summer  Volunteer

Wage: Days/Week \_\_\_\_/\_\_\_\_

Hours/Week \_\_\_\_/\_\_\_\_

Gross Wages \$\_\_\_\_\_ Per  Annual/10 mos  Annual 11 mos  Annual 12 mos  
 Monthly  Bi-monthly  Bi-weekly  
 Daily  Weekly  Hourly

Salary continued under Ed Code  Yes  No

Comments \_\_\_\_\_  
\_\_\_\_\_