

**EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR ILLNESS**

Fatality

Any Person who makes or causes to be made any knowingly false or fraudulent statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER	1. FIRM NAME			1A. POLICY NUMBER	DO NOT USE THIS COLUMN					
	2. MAILING ADDRESS (Number, Street, City and Zip)			2A. PHONE NUMBER		Case No.				
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number, Street, City and Zip)			3A. LOCATION CODE		Ownership				
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.			Industry				
6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____					Occupation					
INJURY OR ILLNESS	7. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.		9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.		10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		Sex	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		12. DATE LAST WORKED (mm/dd/yy)		13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>		Age	
	15. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Daily hours	
	19. 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.									Days per week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street and City)				20A. COUNTY		21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		Weekly Hours	
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.						23. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		Weekly wage	
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.									County
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.									Nature of injury
	26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, eg., 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.									Part of body
										Source
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City and Zip)						27A. PHONE NUMBER			Event	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES THEN, NAME AND ADDRESS OF HOSPITAL (Number, Street, City and Zip)						28A. PHONE NUMBER			Sec. Source	
						29. EMPLOYEE TREATED IN EMERGENCY Room? <input type="checkbox"/> YES <input type="checkbox"/> NO			Extent of injury	

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(2)(E)2.

NOTE: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

EMPLOYEE	30. EMPLOYEE NAME			31. SOCIAL SECURITY		32. DATE OF BIRTH (mm/dd/yy)			
	33. HOME ADDRESS (Number, Street, City and Zip)					33A. PHONE NUMBER			
	34. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		35. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)				36. DATE OF HIRE (mm/dd/yy)		
	37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours			37A. EMPLOYMENT STATUS (check applicable status at time of injury) <input type="checkbox"/> regular full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal			37B. Under what class code of your policy were wages assigned?		
38. GROSS WAGES/SALARY \$ _____ per _____				39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO					

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

Completed by (type or print)	Signature	Title	Date (mm/dd/yy)
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