

State of California <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.						
				FATALITY <input type="checkbox"/>						
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> 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 <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be <b>reported immediately</b> by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.								
EMPLOYER	1. FIRM NAME			1a. Policy Number		Please do not use this column				
	2. MAILING ADDRESS: (Number, Street, City, Zip)			2a. Phone Number			CASE NUMBER			
	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						
	6. TYPE OF EMPLOYER: Private                      State                      County                      City                      School District <input type="checkbox"/> Other Gov't, Specify: _____					INDUSTRY				
INJURY OR ILLNESS	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM		10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)			
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes                      No		12. DATE LAST WORKED (mm/dd/yy)		13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX:			
	15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? Yes                      No		16. SALARY BEING CONTINUED? Yes                      No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)		SEX	
	19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning							AGE		
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)			20a. COUNTY		21. ON EMPLOYER'S PREMISES? Yes                      No		DAILY HOURS		
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.				23. Other Workers injured or ill in this event? Yes                      No				DAYS PER WEEK	
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold							WEEKLY HOURS		
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.							WEEKLY WAGE		
	26. 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							COUNTY		
								NATURE OF INJURY		
							PART OF BODY			
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)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.							SOURCE			
							EVENT			
							SECONDARY SOURCE			
EMPLOYEE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)									
	37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours			37a. EMPLOYMENT STATUS regular, full-time                      part-time temporary                      seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED		EXTENT OF INJURY		
	38. GROSS WAGES/SALARY \$ _____ per _____			39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes                      No						
Completed By (type or print)			Signature & Title				Date (mm/dd/yy)			
* 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.										