

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type, if possible). Mail two copies to:	OSHA Case No. <input type="checkbox"/> Fatality
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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.

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 Safety and Health.

E M P L O Y E R	1. FIRM NAME		1A. POLICY NUMBER	DO NOT USE THIS COLUMN	
	2. MAILING ADDRESS (Number and Street, City, ZIP)		2A. PHONE NUMBER		Case No.
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, 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					

E M P L O Y E E	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yy)	Sex		
	10. HOME ADDRESS (Number and Street, City, ZIP)				10A. PHONE NUMBER	Age	
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	12. OCCUPATION (Regular job title—NO initials, abbreviations or numbers)		13. DATE OF HIRE (mm/dd/yy)		Daily hours	
	14. EMPLOYEE USUALLY WORKS hours per day _____ days per week _____ total weekly hours _____		14A. EMPLOYER 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		14B. Under what class code of your policy were wages assigned?		Days per week
	15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO		Weekly hours		

I N J U R Y O R I L L N E S S	17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)		18. TIME INJURY/ILLNESS OCCURRED A.M. _____ P.M. _____		19. TIME EMPLOYEE BEGAN WORK A.M. _____ P.M. _____		20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		Weekly wage	
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yy)		23. DATE RETURNED TO WORK (mm/dd/yy)		24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>		County	
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Nature of injury	
	29. 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. Part of body									
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)			30A. COUNTY			30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			Source
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.					32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				Event
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold. Sec. Source									
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck. Extent of injury									
	35. 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 materials. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.									

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)			36A. PHONE NUMBER		
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)			37A. PHONE NUMBER		

Completed by (type or print)	Signature	Title	Date
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FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY