State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR	Please complete in triplicate (type if possible) Mail two copies to:					OSHA CASE NO.
ILLNESS						FATALITY
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 five days of knowledge every occupation illness which results in lost time beyond the date of the incident OR requires medical tre first aid. If an employee subsequently dies as a result of a previously reported injury or employer must file within five days of knowledge an amended report indicating death. serious injury, illness, or death must be reported immediately by telephone or telegrap office of the California Division of Occupational Safety and Health.						atment beyond illness, the n addition, every
				1a. Policy Number	Please do not use this Column	
2. MAILING ADDRESS: (Number, Street, City, Zip)						CASE NUMBER
J. LOCATION if different from Mailing Address (Number, Street, City and Zip) 3a.Location Code O 3a.Location Code						OWNERSHIP
Y 4. NATURE OF BUSINESS; e.g Painting contractor, wholesale grocer, sawmill, hotel, etc. 5. State unemployment insurance acct. no. E 5. State unemployment insurance acct. no. 5. State unemployment insurance acct. no.						
R 6. TYPE OF EMPLOYER:	State County	City School District		Other Gov't, Specify:	INDUSTRY	
7. DATE OF INJURY / ONSET OF ILLNESS (mm / dd / yy)	8. TIME INJURY/ILL	NESS OCCURRED M PM	9. TIME EMPLOYEE BEGAN WORK		10. IF EMPLOYEE DIED, DATE OF DEATH (mm / dd / yy)	OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes No	12. DATE LAST WO	DRKED (mm /dd / yy)	13. DATE RETURNED TO WORK (mm / dd / yy)		14. IF STILL OFF WORK, CHECK THIS BOX:	
I 15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST J DAY WORKED? Yes No	16. SALARY BEING Yes	CONTINUED? No	17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm / dd / yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy)	SEX
U 19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g Second degree burns on right arm, tendonitis on left						AGE
Y	HERE EVENT OR EXPOSURE OCCURRED (Number, Street, City,				21. ON EMPLOYER'S PREMISES? Yes No	DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g Shipping department, machine Ves No						
R 24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold:						DAYS PER WEEK
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g Welding seams of metal forms, loading boxes onto truck						WEEKLY HOURS
L 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.						WEEKLY WAGE
E S						COUNTY
S 27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip) 27a. Phone Number						NATURE OF INJURY
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? No Yes If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, 28a. Phone Number City, Zip).						PART OF BODY
29. Employee treated in Emergency Room? Yes No						
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
30. EMPLOYEE NAME			31. SOCIAL SECURITY	NUMBER	32. DATE OF BIRTH (mm /dd / yy)	EVENT
33. HOME ADDRESS (Number, Street, City, Zip)					33a. PHONE NUMBER	SECONDARY
M 34. SEX: 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) 36. DATE OF HIRE (mm / dd / yy)						SOURCE
O 37. EMPLOYEE USUALLY WORKS		37a. EMPLOYMENT S regular, full-time	TATUS part-time	37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES		
E hours per day, day.	total weekly hours	temporary seasonal			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)
	rance claim: and	under certain circumstances to a	public health or law	enforcement agency	14300.35), to others for the purpose c or to a consultant hired by the employ	