State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY ORILLNESS	Please complete. in triplicate (type, if possible). Mail two copies to: Insurance Carrier's Name: Address: City: State: Zip:	OSHA Case No. ☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose ot 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 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 knowledgean 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

2. MAILING ADDRESS (Number and Street, City, ZIP) | 2A. PHONE NUMBER

3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP) | 3A. LOCATION CODE

4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. | 6. STATE UNEMPLOYMENT INSURANCE ACCT. NO.

6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME | 8. SOCIAL SECURITY NUMBER | 9. DATE OF BIRTH

10. HOME ADDRESS (Number and Street, City, ZIP) | 110A. PHONE NUMBER

11. SEX ☐ MALE ☐ FEMALE | 12. OCCUPATION (Regular job title-NO initials, abbreviations or numbers.) | 13. DATE OF HIRE

14. EMPLOYEE USUALLY WORKS
_____ hours per day _____ days per week _____ total weekly hours | 14A. Under what class code of your policy were wages assigned?

15. GROSS WAGES/SALARY PER
$ ☐ HOUR ☐ DAY ☐ WEEK ☐ TWO WEEKS ☐ MONTH ☐ OTHER - SPECIFY _____

INJURY OR ILLNESS

16. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) | 16A. COUNTY | 16B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

17. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.

18. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.

19. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.

20. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tandonitis on left elbow, lead poisoning.

21. 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.

22. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP) | 22A. PHONE NUMBER

23. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)

24. DATE OF INJURY OR ONSET OF ILLNESS	25. TIME INJURY/ILLNESS OCCURRED	26. TIME EMPLOYEE BEGAN WORK	27. IF EMPLOYEE DIED. DATE OF DEATH
	_____ A.M. _____ P.M.	_____ A.M. _____ P.M.	

28. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY?	29 DATE LAST WORKED	30. DATE RETURNED TO WORK	31. IF STILL OFF WORK, CHECK THIS BOX
☐ YES ☐ NO			☐

32. PAID FULL DAY'S WAGES FOR DATE OF INJURY?	33. SALARY BEING CONTINUED?	34. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

35. DATE OF EMPLOYER'S KNOWLDEGE/NOTICE OF INJURY	36. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM	37. EMPLOYMENT STATUS (permanent, temporary part-time, or seasonal)

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODEDBY

Completed by (type or print)	Signature	Title	Date

FORM 5020 (REV. 6)
1992

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY