

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.
	Insurance Carrier's Name: Address: City: State: Zip:		<input type="checkbox"/> 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 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 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.

E M P L O Y E R	1. FIRM NAME		1A. POLICY NUMBER		PLEASE 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					
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		6. STATE UNEMPLOYMENT INSURANCE ACCT. NO.		OWNERSHIP			
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 _____					INDUSTRY			
E M P L O Y E E	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH			
	10. HOME ADDRESS (Number and Street, City, ZIP)		110A. PHONE NUMBER					
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> 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?		AGE			
15. GROSS WAGES/SALARY PER \$ _____ <input type="checkbox"/> HOUR <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> TWO WEEKS <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER - SPECIFY _____					DAILY HOURS			
I N J U R Y  O R  I L L N E S S	16. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		16A. COUNTY		16B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	17. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.					DAYS PER WEEK		
	18. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.					WEEKLY HOURS		
	19. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.					WEEKLY WAGE		
	20. 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.					COUNTY		
	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.					NATURE OF INJURY		
	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)					PART OF BODY		
	24. DATE OF INJURY OR ONSET OF ILLNESS		25. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.		26. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.		27. IF EMPLOYEE DIED, DATE OF DEATH	
	28. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		29. DATE LAST WORKED		30. DATE RETURNED TO WORK		31. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	
32. PAID FULL DAY'S WAGES FOR DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		33. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		34. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXTENT OF INJURY		
35. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY		36. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM		37. EMPLOYMENT STATUS (permanent, temporary part-time, or seasonal)				
Completed by (type or print)		Signature		Title		Date		