EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST CLAIMS ADMINISTRATION

P.O. Box 609015
San Diego, CA 92160
FAX: (858) 277-4519

☐ Fatality

EMPLOYER

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.		Ocupation

EMPLOYEE

5. EMPLOYEE NAME	6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH (mm dd yy)	Age
8. HOME ADDRESS (Number and Street, City, ZIP)		8A. PHONE NUMBER	Daily hours
9. SEX ☐ MALE ☐ FEMALE	10. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)	11. DATE OF HIRE (mm dd yy)	Days per week
12. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours	12A. EMPLOYMENT STATUS (check applicable status at time of injury) _____ regular full time _____ part-time _____ temporary _____ seasonal	12B. DEPARTMENT CODE	Weekly hours
13. GROSS WAGES SALARY $_____ per _____	14. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO		

14. Have you ever injured or received treatment to the same body part? ☐ YES ☐ NO

15. Do you have more than one paying job? ☐ YES ☐ NO	15A. Married? ☐ YES ☐ NO	15B. Dependents? ☐ YES ☐ NO

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me.

NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe.

NOTICE: Making or causing to be made any knowingly false or fraudulent material statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

16. Employee Signature _____ Date _____

INJURY OR ILLNESS

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? ☐ YES ☐ NO	22. DATE LAST WORKED (mm dd yy)	23. DATE RETURNED TO WORK (mm dd yy)	24. IF STILL OFF WORK, CHECK THIS BOX ☐	County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO	26. SALARY BEING CONTINUED? ☐ YES ☐ 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? ☐ YES ☐ NO	Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.		32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ 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 material. 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

Employer comments/concerns

Completed by (type or print)	Signature	Title	Date

TF-107 (12/99)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY