

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.	
				FATALITY <input type="checkbox"/>	
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 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 Occupational Safety and Health.			
EMPLOYER	1. FIRM NAME		1a. Policy Number		Please do not use this column
	2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number		
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		OWNERSHIP
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct.no		
	6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. DATE LAST WORKED (mm/dd/yy)	
13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)	
INJURY OR ILLNESS	19. 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				AGE
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.		23. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS
	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
	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
				COUNTY	
				NATURE OF INJURY	
				PART OF BODY	
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	
				EVENT	
				SECONDARY SOURCE	
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)					
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED	
38. GROSS WAGES/SALARY \$ _____ per _____		39. 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	
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)	