

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			CASE 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: Private State County City 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? Yes No		12. DATE LAST WORKED (mm/dd/yy)		
13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX:		15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? Yes No		
16. SALARY BEING CONTINUED? Yes No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)		
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		
INJURY	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		21. ON EMPLOYER'S PREMISES? Yes No	
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.		23. Other Workers injured or ill in this event? Yes No		DAILY HOURS	
OR	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	
ILLNESSES	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		
				SOURCE		
				EVENT		
				SECONDARY SOURCE		
EMPLOYEE	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 regular, full-time part-time temporary 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.)? Yes No		EXTENT OF INJURY		
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)		
* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.						

Appropriate Administrator or his/her designee Comments/Investigation:

What contributed to the accident/incident?

- | | | |
|--|--|--|
| <input type="checkbox"/> Assistive device not use. | <input type="checkbox"/> Procedure not followed. | <input type="checkbox"/> Other (use separate sheet if necessary) |
| <input type="checkbox"/> Equipment or tool defect/failure. | <input type="checkbox"/> Personal Protective Equipment not worn. | _____ |
| <input type="checkbox"/> Failure to obtain assistance. | <input type="checkbox"/> Rushing or hurried. | _____ |
| <input type="checkbox"/> Improper tool/equipment utilized. | <input type="checkbox"/> Training lacking or incomplete. | |
| <input type="checkbox"/> Inattention to task. | <input type="checkbox"/> Work area arrangement. | |

What corrective action will be taken to prevent recurrence? (check as many as appropriate)

- Safety Guidelines developed/revised.
- Safety Training scheduled.
- Personal Protective Equipment ordered.
- Maintain good housekeeping.
- Repairs ordered/made.
- Other (use separate sheet if necessary) _____

Instructions: To be completed by the Appropriate Administrator or his/her designee (not the employee). Complete ALL information as requested and return to the Workers' Compensation Specialist, 0046.
