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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| State of California<br><b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                     | 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 <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> 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 <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be <b>reported immediately</b> 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, Street, City, Zip)                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 2a. Phone Number                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 3. LOCATION if different from Mailing Address (Number, Street, City and Zip)                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 3a. Location Code                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 5. State unemployment insurance acct.no                                                                                                               |  |
| INJURY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 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)                                                                                                                       |  |
| SOURCES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 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)                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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                                                                                                                                                   |  |
| ILLNESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 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                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | DAILY HOURS                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 27. Name and address of physician (number, street, city, zip)                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 27a. Phone Number                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes then, name and address of hospital (number, street, city, zip)                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 28a. Phone Number                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | SOURCE                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 30. EMPLOYEE NAME                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 31. SOCIAL SECURITY NUMBER                                                                                                                            |  |
| EMPLOYEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 32. DATE OF BIRTH (mm/dd/yy)                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | EVENT                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 33. HOME ADDRESS (Number, Street, City, Zip)                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 33a. PHONE NUMBER                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 36. DATE OF HIRE (mm/dd/yy)                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 | 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 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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) |                                                                                                                                                       |  |
| * 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. |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |                                                                                                                                                       |  |