

State of California	Please complete in triplicate (type, if possible). Mail two copies to:	OSHA Case No.
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		<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.	NOTICE: 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 Safety and Health.
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E M P L O Y E R	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.		5. STATE UNEMPLOYMENT INSURANCE Acct. No.			Industry		
	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 _____					Occupation		
E M P L O Y E E	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH (mm/dd/yy)	Sex		
	10. HOME ADDRESS (Number and Street, City, Zip)				10A. PHONE NUMBER		Age	
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	12. OCCUPATION (Regular job title-NO initials, abbreviations or number)			13. DATE OF HIRE (mm/dd/yy)		Daily Hours	
	14. EMPLOYEE USUALLY WORKS hours _____ days _____ total per day _____ per week _____ weekly hours		14A. EMPLOYMENT STATUS (Check applicable status at time of injury) regular _____ full-time _____ part-time _____ temporary _____ seasonal		14B. Under what class code of your policy were wages assigned?		Day per week	
	15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES SALARY (e.g., tips, meal, lodging, overtime, bonuses, etc.) ? <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO			Weekly hours		
I N J U R Y O R I L L N E S S	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? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yy)		23. DATE RETURNED TO WORK		24. IF STILL OFF WORK CHECK THIS BOX <input type="checkbox"/>	County
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	27. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm/dd/yy)		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FROM (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? <input type="checkbox"/> YES <input type="checkbox"/> NO		Source
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop				32. OTHER WORKERS INJURED/ILL IN THIS EVENTS <input type="checkbox"/> YES <input type="checkbox"/> 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 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			

Completed by (type or print)	Signature	Title	Date
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