

<b>State of California</b>  <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>	Please complete in triplicate (type, if possible) and mail original and one copy to: <b>CLAIMS MANAGEMENT SERVICE</b> P.O. BOX 11828, SANTA ANA, CA 92711 ALSO SEND ONE COPY TO: OFFICE OF EMERGENCY SERVICES - ATTENTION ANITA CHANT 3650 SCHRIEVER AVENUE, MATHER, CA 95655 BOTH SIDES OF THIS FORM MUST BE COMPLETED (Claims Management Service is a division of State Compensation Insurance Fund)	<b>OSHA Case No.</b>  <b>DR</b>  <input type="checkbox"/> Fatality
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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 <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.
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<b>C O U N C I L</b>	1. LOCAL ACCREDITED DISASTER COUNCIL	1a. Policy Number	<b>Please do not use this Column</b>
	2. MAILING ADDRESS (Number and 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. <b>OFFICE OF EMERGENCY SERVICES</b>	5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.	Industry
6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input checked="" type="checkbox"/> OTHER GOVERNMENT - SPECIFY <b>DISASTER COUNCIL</b>			Occupation

<b>I N J U R Y  O R  I L L N E S S</b>	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	Sex	
	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"/>		Age
	15. PAID FULL DAY'S 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)		Daily hours
	19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.				19a. BODY PART AFFECTED	Days per Week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly 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		Weekly Wage
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.					
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.					County
	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.					Nature of Injury
	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	Part of body	
				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.**  
 Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.\*

<b>D I S A S T E R  W O R K E R</b>	30. EMPLOYEE NAME	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)		
	33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER	Event	
	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)	Secondary Source
	37. EMPLOYEE USUALLY WORKS _____ hours _____ days _____ total _____ per day _____ per week _____ weekly hours	37a. EMPLOYMENT STATUS <input type="checkbox"/> disabled <input type="checkbox"/> unemployed <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> retired <input type="checkbox"/> on strike <input type="checkbox"/> temporary <input type="checkbox"/> seasonal <input type="checkbox"/> laid-off <input type="checkbox"/> other		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?	Extent of Injury
	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			
	40. NAME AND ADDRESS OF PRESENT EMPLOYER				Date (mm/dd/yy)
Completed By (type or print)		Signature & Title			

\* 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.

41. OCCUPATION (REGULAR JOB TITLE, NOT SPECIFIC ACTIVITY AT TIME OF INJURY)

42. WAS WORKER REGISTERED WITH A LOCAL ACCREDITED DISASTER COUNCIL? IF SO, WHICH \_\_\_\_\_

43. DID INJURY ARISE OUT OF ACTIVITIES AS A DISASTER SERVICE WORKER? \_\_\_\_\_