

<b>State of California</b>  <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>	Please complete in triplicate (type, if possible). Mail one original and one copy to:  <b>STATE COMPENSATION INSURANCE FUND</b> Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 – 2581.5 for instructions on completion and routing. <b>BOTH SIDES OF THIS FORM MUST BE COMPLETED</b>	<b>OSHA Case No.</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.	<b>NOTICE:</b> 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 teletype to the nearest office of the California Division of Occupational Safety and Health.
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<b>E M P L O Y E R</b>	1. DEPARTMENT	1a. AGENCY CODE OR SCIF 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. DIV./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 checked="" type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____			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	29. Employee treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO	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.\*

<b>E M P L O Y E E</b>	30. EMPLOYEE NAME	CSID#	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)		CBID#	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?	
	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
40. PERS/STRS MEMBERS YES NO		41. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)
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\* 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.

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME

UNIT

SOCIAL SECURITY NUMBER

**SUPERVISOR'S REVIEW**

Facts available lead me to believe this work injury was caused by and happened during State work.

From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.

The facts do not indicate this claim of injury was work connected.

GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS?  YES  NO If no, explain.

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR:  YES  NO

B. MODIFIED WORK DECISION:  Condition precludes M.W.  Appropriate M.W. not available  M.W. arranged \_\_\_\_\_ days

Signature

Classification

Date

**MANAGER'S REVIEW**

DO YOU CONCUR WITH FIRST LINE SUPERVISOR'S REVIEW?  YES  NO If no, explain.

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS:

**STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES**

P.O. Box 21810  
Bakersfield, CA 93390-1810

P.O. Box 910932  
Commerce, CA 90091-0932

P.O. Box 4973  
Eureka, CA 95502-4973

P.O. Box 40000  
Fresno, CA 93755-4000

P.O. Box 9045  
Oxnard, CA 93031-9045

P.O. Box 496049  
Redding, CA 96049-6049

P.O. Box 59901  
Riverside, CA 92517-1901

P.O. Box 1609  
Rohnert Park, CA 94927-1609

P.O. Box 659011  
Sacramento, CA 95865-9011

P.O. Box 530957  
San Jose, CA 95153-5357