State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

OSHA CASE 5

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 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
2. MAILING ADDRESS (Number and Street, City and 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.
6. Type of Employer: ☐ Private ☐ State ☐ County ☐ City ☐ School Dist. ☐ Other Gov't Specify: _____

INJURY OR ILLNESS

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 KILLED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR A 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. STILL OFF WORK, CHECK THIS BOX ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE EMPLOYER'S KNOWLEDGE 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 burn on right arm, tendonitis of left elbow, lead poisoning.
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) — County
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, eg., Shipping Department, Machine Shop.
23. Other Workers Injured or Ill In this event? ☐ YES ☐ NO
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 OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
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 wet clay material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, ZIP) — 27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ No ☐ Yes If yes, then NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip) — 28a. Phone Number
29. Employee treated in Emergency Room? ☐ YES ☐ 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.*

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number and Street, City, Zip) — 33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ Hours/Day _____ Days/Week _____ Total Weekly Hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
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.)? ☐ YES ☐ NO

Completed By (type or print) | Signature & Title | Date (mm/dd/yy)

* Confidential information may be disclosed 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.

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY