Reset Form

**State of California**

**EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

# STATE COMPENSATION INSURANCE FUND

Telephone: (888) STATEFUND or (888) 782-8338 Fax (800) 371-5905

**OSHA Case No.**

☐ 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 Occupational Safety and Health.

## EMPLOYER

1. FIRM NAME DIVISION
1a. Policy Number
2. MAILING ADDRESS (Number and 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.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

**Please do not use this Column**

Case Number

Ownership

Industry

Occupation

## 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 DIED, DATE OF DEATH (mm/dd/yy)

Sex

11. UNABLE TO WORK FOR AT 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. IF STILL OFF WORK, CHECK THIS BOX ☐

Age

15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ 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? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ 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? ☐ YES ☐ 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? ☐ 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

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.*

Source

## EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)

Event

33. HOME ADDRESS (Number, 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)

Secondary Source

37. EMPLOYEE USUALLY WORKS
hours _____ per day days _____ per week total _____ weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ disabled ☐ unemployed ☐ temporary ☐ seasonal ☐ retired ☐ on strike ☐ laid-off ☐ 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.)? ☐ YES ☐ NO

40. Number of employees on most recent policy inception or renewal date in effect at time of injury.

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.



**FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.**