

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail two copies to: Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO. OSHA CASE NO. FATALITY <input type="checkbox"/>	
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.		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.			
EMPLOYER	1. FIRM NAME 1. FIRM NAME		1a. Policy Number 1a. Policy Number		Please do not use this column
	2. MAILING ADDRESS: (Number, Street, City, Zip) 2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number 2a. Phone Number		
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip) 3. LOCATION if different from Mailing Address		3a. Location Code 3a. Location code		OWNERSHIP
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc. 4. NATURE OF BUSINESS;		5. State unemployment insurance acct.no 5. State unemployment insuran		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 District <input type="checkbox"/> Other Gov't, Specify: 6. TYPE OF		7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy) 7. DATE OF ILLNESS		8. TIME INJURY/ILLNESS OCCURRED	
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) 4/4/2004		13. DATE RETURNED TO WORK (mm/dd/yy) 01/01/2008	
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy) 3/3/2003	
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning		19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy) 2/2/2002	
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) 20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED		20a. COUNTY 20a. COUNTY		21. ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop. 22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED,		23. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS	
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold 24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED		25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck. 25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED,		DAYS PER WEEK	
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 26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS,		27. Name and address of physician (number, street, city, zip) 27. Name and address of physician		27a. Phone Number 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) If yes then, name and address of hospital (number, street, city, zip)		29. Employee treated in emergency room? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		WEEKLY HOURS	
29. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		30. EMPLOYEE NAME 30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER . SOCIAL SECURITY NUMBE	
33. HOME ADDRESS (Number, Street, City,Zip) 33. HOME ADDRESS		32. DATE OF BIRTH (mm/dd/yy) 32. DATE OF BIRTH		NATURE OF INJURY	
34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) 35. OCCUPATION		28a. Phone Number 28a. Phone Number	
37. EMPLOYEE USUALLY WORKS 8 hours per day, 5 days per week, 40 total weekly hours		37a. EMPLOYMENT STATUS <input checked="" type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		29. Employee treated in emergency room? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
38. GROSS WAGES/SALARY \$ 22 per hour		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED 37b. UNDER WHAT CLASS		PART OF BODY	
Completed By (type or print) Quy Duong		Signature & Title		SOURCE	
36. DATE OF HIRE (mm/dd/yy) 36. DATE OF HIRE		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		EVENT	
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED 37b. UNDER WHAT CLASS		38. GROSS WAGES/SALARY \$ 22 per hour		SECONDARY SOURCE	
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		37. EMPLOYEE USUALLY WORKS 8 hours per day, 5 days per week, 40 total weekly hours		EXTENT OF INJURY	
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED 37b. UNDER WHAT CLASS		37a. EMPLOYMENT STATUS <input checked="" type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		Date (mm/dd/yy)	