

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail two copies to: SPRINGFIELD INSURANCE COMPANY; P.O. BOX 3029; COVINA, CA 91722 (626) 915-1951 fax (626) 915-2916		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 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 UNIFIED GROCERS, INC.		1a. Policy Number		Please do not use this column CASE NUMBER OWNERSHIP
	2. MAILING ADDRESS: (Number, Street, City, Zip) P.O. BOX 513396		2a. Phone Number (323) 264-5200		
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip) Your Site address		3a. Location Code Site Code		
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct.no		
INJURY	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: _____		INDUSTRY		OCCUPATION
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		
	9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM		10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		
	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)		
OR	13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		SEX
	15. PAID FULL DAYS 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)		
	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				
ILLNESSES	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		DAILY HOURS
	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		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		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.				
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				COUNTY	
27. Name and address of physician (number, street, city, zip)		27a. Phone Number		NATURE OF INJURY	
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		SOURCE	
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*.					
30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/dd/yy)	
33. HOME ADDRESS (Number, Street, City, Zip)				33a. PHONE NUMBER	
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)	
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE 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	
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)	
* 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.					