**State of California**

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

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

# AdminSure

1470 South Valley Vista Drive, Suite 230, Diamond Bar, CA 91765
Self-Insurance Administrators (909) 861-0816

**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 payment 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 **N/A**

2. MAILING ADDRESS (Number, Street, City, Zip)

2A. PHONE NUMBER

3. LOCATION if different from Mailing Address (Number, Street, City, Zip)

3A. LOCATION CODE

4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.

5. STATE UNEMPLOYMENT INSURANCE ACCOUNT NO.

6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ COUNTY ☑ CITY ☐ SCHOOL DISTRICT ☐ OTHER GOVERNMENT - SPECIFY _____

## INJURY OR ILLNESS

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? ☐ 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 ☐

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO

16. SALARY BEING CONTINUED? ☐ YES ☐ NO

17. DATE OF 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 burns on right arm, tendonitis on left elbow, lead poisoning.

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)

20a. COUNTY

21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.

23. OTHER WORKERS INJURED / 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 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.

27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)

27a. PHONE NUMBER

28a. PHONE NUMBER

28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ YES ☐ NO If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)

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, 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 per day, _____ days per 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 $ _____ per _____

| 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 |

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 (CCT Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.



**FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY**