

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type, if possible). Mail two copies to: <h1 style="margin: 0;">AdminSure</h1> 3380 Shelby Street, Ontario, CA 91764-5566 Self-Insurance Administrators (909) 861-0816	OSHA Case No. _____ Fatality <input type="checkbox"/>
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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.
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E M P L O Y E R	1. FIRM NAME			1A. POLICY NUMBER	DO NOT USE THIS COLUMN					
	2. MAILING ADDRESS (Number, Street, City, Zip)			2A. PHONE NUMBER		CASE NUMBER				
	3. LOCATION if different from Mailing Address (Number, Street, City, Zip)			3A. LOCATION CODE		OWNERSHIP				
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		5. STATE UNEMPLOYMENT INSURANCE ACCOUNT NO.			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 GOVERNMENT - SPECIFY _____										
I N J U R Y O R I L L N E S S	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)		OCCUPATION	
	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)		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 OF INJURY / ILLNESS (mm-dd-yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm-dd-yy)		AGE	
	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? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.		DAILY HOURS
	23. OTHER WORKERS INJURED / 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.									
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)									
						27a. PHONE NUMBER		NATURE OF INJURY		
						28a. PHONE NUMBER				
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)						29. EMPLOYEE TREATED IN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> 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.										
E M P L O Y E E	30. EMPLOYEE NAME			31. SOCIAL SECURITY NUMBER			32. DATE OF BIRTH (mm-dd-yy)			SOURCE
	33. HOME ADDRESS (Number, Street, City, Zip)						33a. PHONE NUMBER			EVENT
	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)			SECONDARY SOURCE
	37. EMPLOYEE USUALLY WORKS _____ hours _____ days _____ total _____ per day, _____ per week, _____ 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 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.) <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____ per _____						
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.