

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type, if possible). Mail original and one copy to: STATE COMPENSATION INSURANCE FUND <i>Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 – 2581.5 for instructions on completion and routing.</i> BOTH SIDES OF THIS FORM MUST BE COMPLETED	OSHA Case No. <input type="checkbox"/> Fatality
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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 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.
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E M P L O Y E R	1. DEPARTMENT			1A. AGENCY CODE OR SCIF POLICY NUMBER	DO NOT USE THIS COLUMN		
	2. MAILING ADDRESS (Number and Street, City, ZIP)			2A. PHONE NUMBER		Case No.	
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)			3A. DIV./LOCATION CODE		Ownership	
	4. NATURE OF BUSINESS Governmental Agency		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.			Industry	
	6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input checked="" type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____					Occupation	
	7. EMPLOYEE NAME			CSID#		8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yy)
E M P L O Y E E	10. HOME ADDRESS (Number and Street, City, ZIP)			10A. PHONE NUMBER		Age	
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	12. OCCUPATION (Regular job title—No initials, abbreviations or numbers)		CBID#	13. DATE OF HIRE (mm/dd/yy)	Daily hours	
	14. EMPLOYEE USUALLY WORKS hours per day days per week total weekly hours		14A. EMPLOYMENT STATUS (Check applicable status at time of injury.) <input type="checkbox"/> regular full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		14B. Under what class code of your policy were wages assigned?		Days per week
	_____unemployed _____on strike _____disabled _____retired _____laid						
	15. GROSS WAGES/SALARY WAGES/SALARY (e.g., tips, meals, lodging, per \$ _____			16. OTHER PAYMENTS NOT REPORTED AS <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> NO		Weekly hours	
	17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	18. MILITARY TIME INJURY/ILLNESS OCCURRED	19. MILITARY TIME EMPLOYEE BEGAN WORK	20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		Weekly wage	
I N J U R Y O R I L L N E S S	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	County	
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Nature of injury	
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.					Part of body	
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, ZIP Code)		30A. COUNTY	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		Source	
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.			32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		Event	
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.					Sec. Source	
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.					Extent of Injury	
	35. 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.						
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)				36A. PHONE NUMBER			
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)				37A. PHONE NUMBER			
38. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO		39. PERS/STRS MEMBERS <input type="checkbox"/> YES <input type="checkbox"/> NO		40. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Completed by (type or print)		Signature		Title		Date	

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER
SUPERVISOR'S REVIEW		
Facts available lead me to believe this work injury was caused by and happened during State work.	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.	The facts do not indicate this claim of injury was work connected.
GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:		
WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, explain.		
I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:		
IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY: A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: <input type="checkbox"/> YES <input type="checkbox"/> NO B. MODIFIED WORK DECISION: <input type="checkbox"/> Condition precludes M.W. <input type="checkbox"/> Appropriate M.W. not available <input type="checkbox"/> M.W. arranged _____ days		
Signature	Classification	Date
MANAGER'S REVIEW		
DO YOU CONCUR WITH FIRST LINE SUPERVISOR'S REVIEW? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, explain.		
Signature and Date		

CONTINUATION AND MISCELLANEOUS COMMENTS:

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. Box 21810
Bakersfield, CA 93390-1810

P.O. Box 910932
Commerce, CA 90091-0932

P.O. Box 4973
Eureka, CA 95502-4973

P.O. Box 40000
Fresno, CA 93755-4000

P.O. Box 9045
Oxnard, CA 93031-9045

P.O. Box 496049
Redding, CA 96049-6049

P.O. Box 59901
Riverside, CA 92517-1901

P.O. Box 1609
Rohnert Park, CA 94927-1609

P.O. Box 659011
Sacramento, CA 95865-9011

P.O. Box 530957
San Jose, CA 95153-5357