

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	ACWA/Joint Powers Insurance Authority PO Box 619082 Roseville CA 95661-9082 (916)786-5742 (800) 231-5742	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 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.
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E M P L O Y E R	1. FIRM NAME	1A. POLICY NUMBER	Please 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 and Zip)	3A. LOCATION CODE	OWNERSHIP
	4. NATURE OF BUSINESS; e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc.	5. STATE UNEMPLOYMENT INSURANCE ACCT. 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 _____		OCCUPATION

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)		
	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 NOTICE 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					DAILY HOURS
	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	DAYS PER WEEK
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.			23. Other Workers Injured/ill in this event? <input type="checkbox"/> YES <input type="checkbox"/> NO		WEEKLY HOURS
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.					WEEKLY WAGE
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck					COUNTY
	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.					NATURE OF INJURY
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)			27a. Phone Number		PART OF BODY
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		SOURCE	
			29. Employee treated in Emergency Room? <input type="checkbox"/> <input type="checkbox"/>		EVENT	

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)		
	33. HOME ADDRESS (Number, Street, City, Zip)	33a. PHONE NUMBER		SECONDARY SOURCE	
	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 WERE WAGES ASSIGNED?	EXTENT OF INJURY
	38. GROSS WAGES/SALARY \$ _____ per _____		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY <input type="checkbox"/> YES <input type="checkbox"/> NO (e.g., tips, meals, overtime, bonuses, etc.)?		Date (mm / dd / yy)

Completed By (type or print)	Signature & Title
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*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.