

State of California		Please complete in triplicate (type, if possible). Mail two copies to:		OSHA Case No.		
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Sedgwick CMS Inc. PO Box 14629 Lexington KY 40512-4479		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		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 checked="" 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	
	INJURY OR ILLNESS	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED 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)		
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)		
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				18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)		
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.			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		
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		
				29. Employee treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> 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 <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?	
	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.)?			
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.