State of California Please complete in triplicate (type if possible) Mail two copies to: EMPLOYER'S REPORT OF				OSHA CASE NO.
OCCUPATIONAL INJURY OR ILLNESS				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 denying workers compensation benefits or payment guilty of a felony.	date of the incident OR requires med illness, the employer must file within	report within five days of knowledge every occupati- ical treatment beyond first aid. If an employee subse five days of knowledge an amended report indicat- elephone or telegraph to the nearest office of the Ca	equently dies as a result of a previously report ing death. In addition, every serious injury, illr	ed injury or ness, or death
1. FIRM NAME			la. Policy Number	Please do not use
E 2. MAILING ADDRESS: (Number, Street, City, Zip) A P 2a. Phone Number				CASE NUMBER
L 3. LOCATION if different from Mailing Address (Number, Street, City and Zip) O 3a. Location Code				OWNERSHIP
Y E 4. NATURE OF BUSINESS; e.g Painting contractor, wholesale grocer, sawmill, hotel, etc. 5. State unemployment insurance acct.no				
6. TYPE OF EMPLOYER: Private	State County	City School District	Other Gov't, Specify:	INDUSTRY
7. DATE OF INJURY / ONSET OF ILLNESS 8. TIME INJUI		9. TIME EMPLOYEE BEGAN WORK	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	OCCUPATION
1. UNABLE TO WORK FOR AT LEAST ONE ULL DAY AFTER DATE OF INJURY? Yes No		AMPM 13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK, CHECK THIS BOX:	4
15. PAID FULL DAYS WAGES FOR DATE OF NURY OR LAST YES NO YES		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE O INJURY/ILLNESS (mm/dd/yy)	F 18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)	SEX
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY A	FFECTED, MEDICAL DIAGNOSIS if available, e.g	Second degree burns on right arm, tendonitis on left elb	ow, lead poisoning	AGE
N J 20. LOCATION WHERE EVENT OR EXPOSURE OCCUR U U R Y		20a. COUNTY	21. ON EMPLOYER'S PREMISES? Yes No	DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCC	CURRED, e.g Shipping department, machine shop	p. 23. Other Workers injured Yes	or ill in this event? No	DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS O R	S THE EMPLOYEE WAS USING WHEN EVE	NT OR EXPOSURE OCCURRED, e.g Acetylene, v	welding torch, farm tractor, scaffold	
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS P	ERFORMING WHEN EVENT OR EXPOSURE	OCCURRED, e.g Welding seams of metal forms,	loading boxes onto truck.	WEEKLY HOURS
L L 26 HOW IN HERYILL NESS OCCURRED DESCRIBE SE	OUENCE OF EVENTS SPECIFY OR JECT OR EXP	OSURE WHICH DIRECTLY PRODUCED THE INJURYIILLN	FSS e.g. Worker stenned back to inspect work	WEEKLY WAGE
N and slipped on scrap material. As he fell, he brushed aga E S			200, e.g Horker stepped back to inspect work	COUNTY
S				
				NATURE OF INJURY
				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*.				SOURCE
				EVENT
E M				SECONDARY SOURCE
L 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)				
Y 37. EMPLOYEE USUALLY WORKS		37a. EMPLOYMENT STATUS	37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED	
E hours per day, days p	er week, total weekly hours	regular, full-time part-time temporary seasonal		EXTENT OF INJURY
38. GROSS WAGES/SALARY \$	per	39. OTHER PAYMENTS NOT REPORTED AS WAGES! Yes No	SALARY (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 claim; and under certain circumstances to a public harm. 	ne employee, former employee, or their person	al representative (CCR Title 8 14300.35), to others for	the purpose of processing a workers' compen	sation or other insurance
claim; and under certain circumstances to a public h federal workplace safety agencies.	learth or law enforcement agency or to a cons	unant filred by the employer (CCR Title 8 14300.30).	OOK TILLE 6 14300.40 requires provision upon r	equest to certain state and