State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

SISC I
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

WORKERS' COMPENSATION
PO Box 1847 • BAKERSFIELD, CA 93303-1847
PHONE (661) 636-4710• FAX (661) 636-4721

OSHA Case No.

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 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 ☐ Private ☐ State ☒ County ☐ City ☐ School District ☐ OTHER GOVERNMENT – SPECIFY | OCCUPATION

INJURY OR ILLNESS

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)

SEX

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY ☐ YES ☐ NO
12. DATE LAST WORKED (MM/DD/YY)
13. DATE RETURNED TO WORK (MM/DD/YY)
14. IF STILL OFF WORK, CHECK THIS BOX ☐

AGE

15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)

DAILY HOURS

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? ☐ YES ☐ 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? ☐ YES ☐ 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? ☐ NO ☐ YES If yes then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
29. Employee treated in Emergency Room? ☐ YES ☐ NO

SOURCE

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*

EVENT

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)

SECONDARY SOURCE

33. HOME ADDRESS (Number, Street, City, Zip)
33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)

EXTENT OF INJURY

37. EMPLOYEE USUALLY WORKS hours per day, days per week, total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full time ☐ part-time ☐ temporary ☐ 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 ☐ YES ☐ NO (e.g., tips, meals, overtime, bonuses, etc.)?

Date (mm/dd/yy)

Completed By (type or print)
Signature & Title

*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.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY