

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please type. Mail original and one copy OCTAGON RISK SERVICES	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.

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 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.

E M P L O Y E R	1. FIRM NAME		1A. POLICY NUMBER	PLEASE DO NOT USE THIS COLUMN		
	2. MAILING ADDRESS (Number and Street, City, ZIP)		2A. PHONE NUMBER			
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)		3A. LOCATION CODE			
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.		6. STATE UNEMPLOYMENT INSURANCE ACCT. NO.	OWNERSHIP		
6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____				INDUSTRY		
E M P L O Y E E	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER N/A	9. DATE OF BIRTH N/A	OCCUPATION	
	10. HOME ADDRESS (Number and Street, City, ZIP)		110A. PHONE NUMBER		SEX	
	11. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	12. OCCUPATION (Regular job title-NO initials, abbreviations or numbers.)		13. DATE OF HIRE		
	14. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours		14A. Under what class code of your policy were wages assigned?		AGE	
	15. GROSS WAGES/SALARY PER \$ _____ <input type="checkbox"/> HOUR <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> TWO WEEKS <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER - SPECIFY _____				DAILY HOURS	
16. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		16A. COUNTY	16B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		DAYS PER WEEK	
17. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.					WEEKLY HOURS	
18. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.					WEEKLY WAGE	
19. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.					COUNTY	
20. 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.					NATURE OF INJURY	
21. 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.					PART OF BODY	
22. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)			22A. PHONE NUMBER		SOURCE	
23. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)					ACCIDENT TYPE	
24. DATE OF INJURY OR ONSET OF ILLNESS	25. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	26. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	27. IF EMPLOYEE DIED. DATE OF DEATH _____		A.O.S.	
28. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		29. DATE LAST WORKED	30. DATE RETURNED TO WORK	31. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>		EXTENT OF INJURY
32. PAID FULL DAY'S WAGES FOR DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		33. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO		34. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO		CODEDBY
35. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY		36. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM		37. EMPLOYMENT STATUS (permanent, temporary part-time, or seasonal)		
Completed by (type or print)		Signature		Title		Date