

State of California DEPARTMENT OF CORRECTIONS REPORT OF INMATE OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate (type, if possible). Mail original and one copy to: STATE COMPENSATION INSURANCE FUND P.O. BOX 659011 SACRAMENTO, CA 95865-9011 BOTH SIDES OF THIS FORM MUST BE COMPLETED	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.

NOTICE: 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.

E M P L O Y E R	1. DEPARTMENT CDC <input type="checkbox"/> CDF <input type="checkbox"/> PIA <input type="checkbox"/> IDL <input type="checkbox"/> OTHER <input type="checkbox"/>	1a. AGENCY CODE OR SCIF POLICY NUMBER	Please do not use this Column	
	2. MAILING ADDRESS (Number and Street, City, ZIP)	2a. Phone Number		Case Number
	3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)			Ownership
	4. NATURE OF BUSINESS Governmental Agency	5. CDC INSTITUTION (DIVISION CODE)		Industry
6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input checked="" type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <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. MILITARY TIME INJURY/ILLNESS OCCURRED	9. MILITARY TIME EMPLOYEE BEGAN WORK	10. IF INMATE DIED, DATE OF DEATH (mm/dd/yy)	Sex	
	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 <input type="checkbox"/> N/A (mm/dd/yy)	14. IF STILL OFF WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		Age
	15. NUMBER OF LAY-IN DAYS AS A RESULT OF THIS INJURY	16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF WORK RELATED INJURY/ILLNESS (mm/dd/yy)	18. DATE INMATE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)		Daily hours
	19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.				19a. BODY PART AFFECTED	Days per Week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Hours
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.			23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		Weekly Wage
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.					County
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.					Nature of Injury
	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.					Part of body
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip or Institution)				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.*

I N M A T E	30. INMATE NAME	CDC#	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	Event	
	33. INMATE ADDRESS (HOME OR INSTITUTION)					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 INMATE ASSIGNED TO POSITION (mm/dd/yy)		Secondary Source
	37. INMATE USUALLY WORKS _____ hours _____ days _____ total _____ per day _____ per week _____ weekly hours		37a. ESTIMATE PAROLE RELEASE DATE		37b. DATE OF INCARCERATION	Extent of Injury
38. GROSS WAGES/SALARY \$ _____ per _____						

Completed By (type or print)	Signature	Employee Supervisor (type or print)	Phone	Date (mm/dd/yy)
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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 (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

INMATE NAME	CDC #	UNIT	SOCIAL SECURITY NUMBER
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SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work.	<input type="checkbox"/>	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment.	<input type="checkbox"/>	The facts do not indicate this claim of injury was work connected.	<input type="checkbox"/>
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GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? YES NO If no, explain.

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

DID INMATE RECEIVE TRAINING PRIOR TO BEING PLACED INTO POSITION? YES NO
IF YES, HOW MANY HOURS (BOTH JOB AND SAFETY TRAINING) _____ ?

Signature	Classification	Phone Number	Date
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MANAGER'S REVIEW

DO YOU CONCUR WITH FIRST LINE SUPERVISOR'S REVIEW? YES NO If no, explain.

Signature and Date	Phone Number
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COMMENTS: