State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE COMPENSATION INSURANCE FUND

CLAIMS REPORTING: Electronic First Report of Injury (EFROI) using your State Fund ID & Password at: www.statefundca.com/statecontracts or fax to the Customer Service Center at 800-371-5905

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.

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.

EMPLOYER

1. DEPARTMENT
1a. AGENCY CODE OR SCIF POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)
3a. DIV./LOCATION CODE
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 DIST. ☐ OTHER GOVERNMENT - SPECIFY ____________

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED ________ A.M. ________ P.M.
9. TIME EMPLOYEE BEGAN WORK ________ A.M. ________ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
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 ☐
15. PAID FULL DAY'S 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 EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)
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
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)
20a. ZIP
20b. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ 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? ☐ 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

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 ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
CBID#
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS ______ hours per day ________ days per week _________ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal ☐ disabled ☐ retired ☐ laid-off ☐ unemployed ☐ on strike ☐ other
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY $ ___________________ per ___________________
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO
40. PERS/STRS MEMBERS ☐ YES ☐ NO
41. CSID # (3 digit division, 4 digit position or job classification, 3 digit serial number)

Completed By (type or print) | Signature & Title | Date (mm/dd/yy)

Please do not use this Column
Case Number
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per Week
Weekly Hours
Weekly Wage
County
Nature of Injury
Part of body
Source
Event
Secondary Source
Extent of Injury

* 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.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

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 entirely to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work. ☐	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. ☐	The facts do not indicate this claim of injury was work connected. ☐

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:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: ☐ YES ☐ NO

B. MODIFIED WORK DECISION: ☐ Condition precludes M.W. ☐ Appropriate M.W. not available ☐ M.W. arranged___________days

Signature	Classification	Date

MANAGER'S REVIEW

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

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS: