Stanislaus County

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

"EMPLOYEE ON THE JOB INJURY/ILLNESS REPORT"

Fax Immediately or Scan Immediately to
Stanislaus County, CEO-Risk Management Division
1010 10th Street, Suite 5900, Modesto CA 95354
Phn 209-525-5710 Fax: 209-525-5779 email: scdm@stancounty.com

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.

DEPARTMENT

DEPARTMENT / DIVISION / UNIT	**MPN BROCHURE PROVIDED**
LOCATION ADDRESS (Number and Street, City, ZIP)	PHONE NUMBER
SUPERVISOR NAME	PHONE NUMBER
SUPERVISOR ACCIDENT INVESTIGATION REPORT ASSIGNED TO OR COMPLETED BY	PHONE NUMBER

EMPLOYEE

EMPLOYEE NAME (AS IT APPEARS ON YOUR PAYCHECK)	SOCIAL SECURITY #	DATE OF BIRTH (mm/dd/yy)
HOME ADDRESS (Number and Street, City, ZIP)		PHONE NUMBER
SEX ☐ MALE ☐ FEMALE	OCCUPATION (Regular job title–JOB CLASSIFICATION)	DATE OF HIRE (mm/dd/yy)
EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours	EMPLOYMENT STATUS (check applicable status at time of injury) ☐ regular full-time ☐ part-time ☐ temporary ☐ seasonal	
GROSS WAGES/SALARY **(COMPLETED BY RMD)** $ ____ per ____	OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? **Completed by RMD** ☐ YES, $ ____ per ____ ☐ NO	

INJURY OR ILLNESS

DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	TIME INJURY/ILLNESS OCCURRED ____ A.M. ____ P.M.	TIME EMPLOYEE BEGAN WORK ____ A.M. ____ P.M.	F EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO	22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	IF STILL OFF WORK, CHECK THIS BOX ☐
PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO	SALARY BEING CONTINUED? **TO BE COMPLETED BY RMD** ☐ YES ☐ NO	DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM – **DWC-1** (mm/dd/yy)

29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.

LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)	COUNTY	ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
AREA OR UNIT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.		OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO

EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.

SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.

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.

NAME AND ADDRESS OF PHYSICIAN OR OCCUPATIONAL PROVIDER (Number and Street, City, ZIP)	PHONE NUMBER
IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)	PHONE NUMBER

Completed by (type or print)	Signature	Title