

<b>State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>	 <b>Sedgwick CMS</b> P.O. Box 2065 – Oakland, CA. 94604-0065 Telephone (510) 302-3000 FAX No. (510) 302-3264	<b>OSHA Case No.</b>  Fatality <input type="checkbox"/>
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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 telegram to the nearest office of the California Division of Occupational Safety and Health.

<b>E M P L O Y E R</b>	1. FIRM NAME <b>Foothill-De Anza Community College District</b>	1a. Policy Number <b>FHDA-01</b>	<b>Do not use this Column</b>
	2. MAILING ADDRESS (Number and Street, City, Zip) <b>12345 El Monte Road, Los Altos Hills, CA 94022</b>	2a. Phone Number <b>(650) 949-6224</b>	CASE NUMBER
	3. LOCATION, If different from Mailing Address (Number and Street, City and Zip)	3a. Location Code	OWNERSHIP
	4. NATURE OF BUSINESS e.g. painting contractor, wholesale grocer, sawmill, hotel, etc. <b>Education</b>	5. State Unemployment Insurance acct. no.	INDUSTRY
	6. TYPE OF EMPLOYER <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> County <input checked="" type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____		OCCUPATION

<b>I N J U R Y  O R  I L L N E S S</b>	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. DATE LAST WORKED mm/dd/yy	13. DATE RETURNED TO WORK (mm/dd/yy)	14. IF STILL OFF WORK CHECK THIS BOX <input type="checkbox"/>	AGE	
	15. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED* <input type="checkbox"/> YES <input type="checkbox"/> NO	16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	17. DATE OF EMPLOYERS KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED EMPLOYEE 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 of left elbow, lead poisoning				DAYS PER WEEK	
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		20A. COUNTY	21. ON EMPLOYERS PREMISES? <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/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)			27a. Phone Number		SOURCE
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> Yes <input type="checkbox"/> No 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		EVENT	

**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.\*

<b>E M P L O Y E E</b>	30. EMPLOYEE NAME	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	SECONDARY SOURCE	
	33. HOME ADDRESS ((number and Street, City, Zip)			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 OF HIRE mm/dd/yy	
	37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours	37a. EMPLOYMENT STATUS (check applicable status at time of injury. <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> student intern <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		137b. Under what class code of your policy were wages assigned?	EXTENT OF INJURY
	38. GROSS WAGES/SALARY \$ _____ per _____		39. OTHER PAYMENT NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, lodging overtime, bonuses, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO		
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)	

\* 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.