State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

SAN JOAQUIN COUNTY
RISK MANAGEMENT
44 N SAN JOAQUIN ST., SUITE 330
STOCKTON, CA 95202

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** telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: **SAN JOAQUIN COUNTY**

2. MAILING ADDRESS (Number and Street, City, Zip)

3. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, hotel, etc.: **COUNTY GOVERNMENT**

4. STATE UNEMPLOYMENT INSURANCE ACCT.NO.

5. DEPARTMENT

5A. HOME DEPARTMENT CODE

6. TYPE OF EMPLOYER
☐ Private ☐ State ☐ City ☒ County ☐ School District ☐ Other-Government-Specify: _____

EMPLOYEE

7. EMPLOYEE NAME

7A. SOCIAL SECURITY NUMBER

8. EMPLOYEE ID NUMBER

9. HOME ADDRESS (Number and Street)

9B. HOME PHONE NUMBER

10. DATE OF BIRTH (mm/dd/yy)

9A. CITY, STATE, ZIP

11. SEX
☐ Male ☐ Female

12. OCCUPATION (Payroll Title)

12A. TITLE CODE

13. DATE OF HIRE (mm/dd/yy)

14. EMPLOYEE USUALLY WORKS
_____ HOURS PER DAY _____ DAYS PER WEEK _____ TOTAL WEEKLY HOURS

14A. EMPLOYMENT STATUS (Check applicable status at time of injury)
☐ REGULAR FULL-TIME ☐ PART-TIME ☐ TEMPORARY ____ OTHER

14B. Does the employee accrue sick leave?
☐ YES ☐ NO

15. GROSS WAGES/SALARY
$ per (hr or wk)

15A. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (*e.g. tips, meals, lodging, overtime, bonuses, etc.*)
☐ YES, $ _____ per _____ ☐ NO

16. SUPERVISOR'S NAME

16A. SUPERVISOR'S E-MAIL

16B. SUPERVISOR'S PHONE

16C. EMPLOYEE'S WORK PHONE

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)

18. TIME INJURY/ILLNESS OCCURRED
____ A.M. ____ P.M.

19. TIME EMPLOYEE BEGAN WORK
____ A.M. ____ P.M.

20. IF EMPLOYEE DIED,DATE OFDEATH (mm/dd/yy)

21. 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)

24. IF STILL OFF WORK, CHECK THIS BOX ☐

25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO

26. SALARY BEING CONTINUED? ☐ YES ☐ NO

27. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)

28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)

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

30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (*Street, Building, Room*)

30A. COUNTY: **SAN JOAQUIN COUNTY**

30B. ON EMPLOYER'S PREMISES?
☐ YES ☐ NO

31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED (*e.g., shipping department, machine shop, room number)*

32. OTHER WORKERS INJURED/ILL IN THIS EVENT?
☐ YES ☐ NO

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

34. WHAT WAS EMPLOYEE DOING WHEN THE INJURY/ILLNESS Occurred, e.g., welding seams of metal forms, loading boxes onto truck, lifting binders.

35. 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*). (SPACE WILL EXPAND TO ACCOMMODATE YOUR DESCRIPTION)

36. NAME AND CITY OF PHYSICIAN WHO TREATED EMPLOYEE FOR THIS INJURY

36a. PHONE NUMBER

37. IF HOSPITALIZED AS AN INPATIENT, NAME AND CITY OF HOSPITAL

38. PHONE NUMBER

39. DEPARTMENT REPRESENTATIVE WHO COMPLETED THIS FORM
Name:
Phone:

40. EMPLOYER COMMENTS (space will expand)

Date

FORM e-5020 SJC

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY