

<b>State of California</b>  <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>	<b>SAN JOAQUIN COUNTY</b> <b>RISK MANAGEMENT</b> <b>44 N SAN JOAQUIN ST., SUITE 330</b> <b>STOCKTON, CA 95202</b>
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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 <b>FIVE DAYS</b> 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 <b>FIVE DAYS</b> of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported <b>IMMEDIATELY</b> telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.
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EMPLOYER	1. FIRM NAME <b>SAN JOAQUIN COUNTY</b>		
	2. MAILING ADDRESS (Number and Street, City, Zip)		
	3. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, hotel, etc. <b>COUNTY GOVERNMENT</b>		4. STATE UNEMPLOYMENT INSURANCE ACCT.NO.
	5. DEPARTMENT	5A. HOME DEPARTMENT CODE	
	6. TYPE OF EMPLOYER <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> School District <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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) <input type="checkbox"/> REGULAR FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> TEMPORARY   _____ OTHER			14B. Does the employee accrue sick leave? <input type="checkbox"/> YES <input type="checkbox"/> 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.) <input type="checkbox"/> YES, \$ _____ per _____ <input type="checkbox"/> 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 OF DEATH (mm/dd/yy)
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>
	25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> 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 <b>SAN JOAQUIN COUNTY</b>	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO
	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED (e.g., shipping department, machine shop, room number)			32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> 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
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