

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 THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE EMPLOYEE PAGE 1 of 2	OSHA Case No. <input type="checkbox"/> 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.
---	--

E M P L O Y E R	1. DEPARTMENT	1a. AGENCY CODE OR STATE FUND POLICY NUMBER	Please do not use this Column
	2. MAILING ADDRESS (Number and Street, City, Zip)	2a. Phone Number	Case Number
	3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)	3a. DIV./LOCATION CODE	Ownership
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.	5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.	Industry
	6. TYPE OF EMPLOYER <input type="checkbox"/> PRIVATE <input checked="" type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____		Occupation

I N J U R Y O R I L L N E S	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)	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 DAY'S WAGES FOR DATE 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 EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)		Daily hours
	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	Days per Week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <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 OR 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.					
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.					County
	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.					Nature of Injury
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)				27a. Phone Number	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)				28a. Phone Number	Part of body	
				29. Employee treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> 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.*

E M P L O Y E E	30. EMPLOYEE NAME	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	Source	
	33. HOME ADDRESS (Number, Street, City, Zip)			33a. PHONE NUMBER	Event
	34. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)	CBID #	36. DATE OF HIRE (mm/dd/yy)	Secondary Source
	37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours		37a. EMPLOYMENT STATUS <input type="checkbox"/> disabled <input type="checkbox"/> unemployed <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> retired <input type="checkbox"/> on strike <input type="checkbox"/> temporary <input type="checkbox"/> seasonal <input type="checkbox"/> laid-off <input type="checkbox"/> 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.?) <input type="checkbox"/> YES <input type="checkbox"/> NO		Extent of Injury
	40. PERS/STRS MEMBERS <input type="checkbox"/> YES <input type="checkbox"/> 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)	

* 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.

Complete the following questions as accurately as possible to the best of your knowledge, but do not delay submission of this form to State Fund. THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE EMPLOYEE.

PAGE 2 of 2

EMPLOYEE'S NAME	UNIT
-----------------	------

42. EMPLOYER REPRESENTATIVE CONTACT INFORMATION (WHO IS THE BEST PERSON TO PROVIDE ADDITIONAL INFORMATION REGARDING THIS CLAIM?)
(Full Name, Title, Phone #, Email Address)

43. WERE THERE ANY WITNESSES TO THE ALLEGED INCIDENT OR INJURY? YES NO UNKNOWN

IF YES, WHAT IS THE WITNESS CONTACT INFORMATION?
(Full Name, Title, Phone #, Email Address)

44. WAS THE INJURY CAUSED BY THE FAULT OF ANOTHER PERSON, A THIRD PARTY, OR BY DEFECTIVE EQUIPMENT? YES NO UNKNOWN

45. ARE YOU AWARE OF THE INJURED WORKER HAVING SECONDARY EMPLOYMENT? YES NO UNKNOWN

46. ARE THERE ANY DISPUTES REGARDING THE INJURY? YES NO UNKNOWN

47. IS THERE ANY ADDITIONAL FACTUAL INFORMATION THAT IS RELEVANT TO THIS CLAIM?