

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.	
				FATALITY <input type="checkbox"/>	
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.		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.			
EMPLOYER	1. FIRM NAME			1a. Policy Number	
	2. MAILING ADDRESS: (Number, Street, City, Zip)			2a. Phone Number	
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)			3a. Location Code	
	4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.			5. State unemployment insurance acct.no	
6. TYPE OF EMPLOYER:		Private State County City School District		<input type="checkbox"/> Other Gov't, Specify: _____	
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)		11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes No		12. DATE LAST WORKED (mm/dd/yy)	
13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX:		15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? Yes No	
16. SALARY BEING CONTINUED? Yes No		17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)	
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning					AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)			20a. COUNTY		21. ON EMPLOYER'S PREMISES? Yes No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.			23. Other Workers injured or ill in this event? Yes No		
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold					DAILY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.					DAYS PER WEEK
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					WEEKLY HOURS
					WEEKLY WAGE
					COUNTY
					NATURE OF INJURY
					PART OF BODY
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*.					SOURCE
					EVENT
					SECONDARY SOURCE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)					
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours			37a. EMPLOYMENT STATUS regular, full-time part-time temporary seasonal		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY \$ _____ per _____			39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes 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.					

POLICY NO.	
EMPLOYEE	
EMPLOYER	
DATE OF INJURY	

Please help us process your new claim more efficiently and complete mandatory state reporting requirements by answering the following additional questions.

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(1) Was the DWC-1 claim form given to the employee? Yes No

- Date employee was provided DWC-1 claim form: _____
- Date employee returned completed claim form: _____

(2) Was the Medical Provider Network "Notification of Rights" given to the employee? Yes No

- Date employee was provided MPN information: _____

(3) Does the employee speak English? Yes No

- If no, please specify other primary language: _____



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Any additional information you may wish to provide to assist Republic Indemnity in making an appropriate decision, i.e., whether to accept, delay, deny or to prompt further in-depth investigation. For example, was the claim reported after the employee terminated? Was the claim reported late? If the injury was unwitnessed, do you have reason to believe that it did not occur? Does the employee have pre-existing or non-industrial medical conditions?

Please be certain of your facts — Unnecessary or improper delay of benefits may cause the claim to be more costly.

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We may need to contact you to verify certain information that was received regarding this claim.

(1) Preparer Name and Title: _____

(2) Please complete and indicate your preferred method of communication:

<input type="radio"/> Phone	_____
<input type="radio"/> Fax	_____
<input type="radio"/> eMail	_____

(3) Today's Date: _____

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Thank you for your prompt reporting.

Should you wish to submit a completed claim form, medical report, or other information regarding this claim, our claims fax number is 818.789.7286 or eMail us at riclaims@ri-net.com.

Our Claims Mailing Address: P.O. Box 20036, Encino, CA 91416-0036. Toll Free Phone: 800.821.4520, option 1.

For a Doctor/Clinic closest to your business, visit the MPN website at www.talispoint.com/ri or call **877.854.3353**.