State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS This form to be completed by agency/supervisor/director. Please e-mail or fax directly to Risk Management and mail original to the Risk Management address indicated below:



COUNTY OF VENTURA

CEO/RISK MANAGEMENT 800 South Victoria Avenue, L#1970 4th floor

800 South Victoria Avenue, L#1970 4th floor Ventura, CA. 93009 (805) 654-3197 (phone) (805)648-9238 (fax) E-mail: <u>Risk.Management@ventura.org</u>

RISK MANAGEMENT USE ONLY
CLAIM NUMBER
AGENCY CODE
OSHA No.
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 follow:

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.

	1. AGENCY NAME	GENCY NAME 1A. DEPT/DIV/BUDGET UNIT							1B. AGENCY'S HR PHONE NUMBER			
Е	2. ADDRESS (NUMBER, STREET, STATE, CITY, ZIP) 3. DEPARTMENT/DIVISION/BUREAU											
M P									2A. EMPLOYEE'S DEPARTMENT PHONE NO.			
L O									3A. EMPLOYEE'S SUPERVISOR PHONE NO.			
Υ Ε	4. NATURE OF BUSINESS COUNTY GOVERNMENT								TATE UNEMPLOYMENT INSURANCE ACCT. No. 944-0101-5			
R						OOL DIST.	GOVERNMENT - SPECIFY					
	7. EMPLOYEE NAME	SIX DIGIT EMPL	SIX DIGIT EMPLOYEE ID 8. SOCIAL SECURITY NUMBER 9. DA				TE OF BIRTH					
M	M ' · · · · · · · · · · · · · · · · · ·						10A. PHO	10A. PHONE NUMBER				
P L O	11. SEX 12. OCCUPATION (REGULAR JOB TITLE—NO INITIALS, ABBREVIATIONS OR NUMBERS) 13. DAT						OF HIRE					
Υ	14. EMPLOYEE USUALLY WORKS	14A. EMPLOYMENT	STATUS (CHECK AF	PLICABLE STAT	US AT TIME OF IN	JURY) 15A. GRO	SS WAGES/SALA	ARY				
E	HOURS DAYS TOTAL REGULAR PER DAY PER WEEK WEEKLY HOURS FULL TIME PART TIME TEMPORARY SEASONAL						PER					
	15B. OTHER PAYMENTS NOT REPORTED AS WAGES/ overtime, bonuses, etc.)? YES	SALARY (e.g., tips, meals, lodging,	16. NA	MES OF WITNE	SSES/PHONE NUI	MBER						
	17. DATE OF INJURY OR ONSET OF ILLNESS								TH.			
		A.M.	P.M.	A.M.	P.M.							
	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY	AFTER DATE OF 22. DATE L	AST WORKED	23.	DATE RETURNED	To Work	24. IF STILL O					
	INJURY? YES NO						CHECK TH	IS BOX				
I N J	N LAST DAY WORKED? NO YES NO NOTICE OF I				LOYER'S KNOWLEDGE/ URY/ILLNESS 28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (RM-1350)							
U R	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AR	FFECTED, MEDICAL DIAGNOSIS	DONITIS OF LEFT ELBC	W, LEAD POISONING).								
Y	30. LOCATION WHERE EVENT OR EXPOSURE OCCUR	30A. COUNT	30B. ON EMPLOYER'				PREMISES? YES NO					
O R	B1. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, E.G., SHIPPING DEPARTMENT, MACHINE SHOP.					32. OTHER WORKERS INJURED/ILL IN THIS EVENT? YES					NO	
I L	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED (e.g., ACETYLENE, WELDING TORCH, FARM TRACTOR, SCAFFOLD).											
N 34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED (e.g., welding seams of metal forms, loading boxes onto truck).												
S	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 supped on so material, as he fell, he brushed against fresh weld and burned right hand). Use Separate Sheet If Necessary.										ON SCRAP	
S												
	36. NAME AND ADDRESS - TREATING PHYSICIAN / ER		36A. F				PHONE NUMBER					
	37. IF HOSPITALIZED AS AN INPATIENT, NAME AND A	(IP) HOSPI	HOSPITALIZED AS INPATIENT OVERNIGHT? YES NO 37A. F				PHONE NUMBER					
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.												
COMPLETED BY SUPERVISOR (TYPE OR PRINT) SIGNATURE SIGNATURE			oj-(10) & 14300.35	(IJ)(∠)(⊏)∠. Note	TITLE				nation as listed in CCR Title 8 14300.35(b)(2)(E)2*. DATE			
• 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.												