State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

MAIL ORIGINAL AND COPIES TO:
Acclamation Insurance Management Services (AIMS)
PO Box 269120, Sacramento, CA 95826: Phone (916) 563-1900, Fax (916) 563-1919
OR EMAIL To 5020Alameda @ 5020Alameda@Aims4Claims.com

OSHA CASE 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 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: **COUNTY OF ALAMEDA, 125 - 12th Street, 3rd Floor, Oakland, CA 94607, (510) 272-6045**

1a. Policy Number: **NONE**

Please do not use this column

2. NAME OF AGENCY/DEPARTMENT (e.g. HCSA, SSA, ACSO) AND NAME OF UNIT (e.g. PH, Welfare to Work, Santa Rita Jail)

2a. WC LIAISON PHONE #

CASE NUMBER

3. EMPLOYEE WORK LOCATION, Mailing Address (Number, Street, City, Zip)

3a. Location Code (BLDG. #)

OWNERSHIP

4. NATURE OF BUSINESS: e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: **COUNTY GOVERNMENT**

5. State unemployment insurance acct.no: **944-0123-9**

6. TYPE OF EMPLOYER: ☐ Private ☐ State ■ County ☐ City ☐ School District ☐ Other Gov't, Specify:

INDUSTRY

INJURY OR ILLNESS

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)

OCCUPATION

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)

SEX

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

DAILY HOURS

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.

23. Other Workers injured or ill in this event? ☐ Yes ☐ No

DAYS PER WEEK

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold

WEEKLY HOURS

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.

WEEKLY WAGE

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, 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

COUNTY

27. Name and address of physician (number, street, city, zip)

27a. Phone Number

NATURE OF INJURY

28. Hospitalized as an inpatient overnight? ☐ No ☐ 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? ☐ Yes ☐ 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*.

SOURCE

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

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

EVENT

33. HOME ADDRESS (Number, Street, City,Zip)

33a. PHONE NUMBER

SECONDARY SOURCE

34. SEX ☐ Male ☐ Female

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

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

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

EXTENT OF INJURY

38. GROSS WAGES/SALARY $ ____ per ____

39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (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.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY