

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

EMPLOYEE NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
SEX M F OCCUPATION \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_  
DEPARTMENT \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_  
HRS WORKED PER DAY \_\_\_ DAYS PER WEEK \_\_\_ TOTAL WEEKLY HRS \_\_\_\_\_  
GROSS WAGES/SALARY \_\_\_ PER HOUR TWO WEEKS MONTH OTHER \_\_\_\_\_  
WHAT WAS EMPLOYEE DOING WHEN INJURED \_\_\_\_\_

HOW DID ACCIDENT OR EXPOSURE OCCUR? \_\_\_\_\_

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DESCRIBE THE INJURY OR ILLNESS (STRAIN, FRACTURE, ETC.) BODY PART  
AFFECTED \_\_\_\_\_

DID EMPLOYEE REPORT TO HEALTH SERVICE? YES \_\_\_ NO \_\_\_  
DID EMPLOYEE GO TO JOBCARE AT ST. HELENA HOSPITAL? YES \_\_\_ NO \_\_\_  
IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL \_\_\_\_\_  
DATE OF INJURY OR ILLNESS \_\_\_\_\_ TIME OF DAY \_\_\_\_\_ AM/PM  
DID EMPLOYEE LOSE A DAY'S WORK? \_\_\_ (IF YES, DATE LAST WORKED) \_\_\_  
WAS EMPLOYEE PAID FOR DATE OF INJURY? \_\_\_ DATE CLAIM FORM  
PROVIDED BY EMPLOYER \_\_\_\_\_  
HAS EMPLOYEE RETURNED TO WORK? \_\_\_ DID EMPLOYEE DIE? \_\_\_\_\_  
IF YES, DATE OF DEATH \_\_\_\_\_

SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(DUE WITHIN 24 HOURS OF ACCIDENT OR INJURY)





**EMPLOYEE'S CLAIM FOR  
WORKERS' COMPENSATION BENEFITS**

**PETICION DEL EMPLEADO PARA BENEFICIOS  
DE COMPENSACIÓN DEL TRABAJADOR**

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al 1-800-736-7401. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

**Employee: Empleado:**

1. Name. Nombre. \_\_\_\_\_ Today's Date. Fecha de Hoy. \_\_\_\_\_
2. Home address. Dirección Residencial. \_\_\_\_\_
3. City. Ciudad. \_\_\_\_\_ State. Estado. \_\_\_\_\_ Zip. Código Postal. \_\_\_\_\_
4. Date of Injury. Fecha de la lesión (accidente). \_\_\_\_\_ Time of injury. Hora en que ocurrió \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. Dirección/lugar dónde ocurrió el accidente. \_\_\_\_\_
6. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. \_\_\_\_\_
7. Social Security Number. Número de Seguro Social del Empleado. \_\_\_\_\_
8. Signature of employee. Firma del empleado. \_\_\_\_\_

**Employer - complete this section and give the employee a copy immediately as a receipt.  
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.**

9. Name of employer. Nombre del empleador. Pacific Union College
10. Address. Dirección. One Angwin Ave., Angwin, CA 94508
11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. \_\_\_\_\_
12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la petición. \_\_\_\_\_
13. Date employer received claim form. Fecha en que el empleado devolvió la petición al empleador. \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. Cambridge Insurance, P.O. Box 4142, Concord, CA 94520-2155 925-603-5557
15. Insurance Policy Number. El número de la póliza del Seguro. 0045938
16. Signature of employer representative. Firma del representante del empleador. *Jolann Bowen*
17. Title. Título. Workers' Comp. Coord. 18. Date. Fecha. \_\_\_\_\_ 19. Telephone. Teléfono. (707) 965-6232

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

**Empleador:** Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

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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. FIRM NAME		1a. Policy Number		Please do not use this column
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		CASE NUMBER
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct.no		OWNERSHIP
6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY
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? <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"/>	SEX
15. PAID FULL DAYS 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 FORM (mm/dd/yy)	AGE
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				DAILY HOURS
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	DAYS PER WEEK
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 HOURS
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold				WEEKLY WAGE
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		PART OF BODY
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		SOURCE
29. Employer treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		29a. Phone Number		EVENT
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*.				SECONDARY SOURCE
30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		EXTENT OF INJURY
32. HOME ADDRESS (Number, Street, City, Zip)		32a. PHONE NUMBER		
34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		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 <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		
38. GROSS WAGES/SALARY \$ _____ per _____		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED		
		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)
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