State of California
EMPLOYER'S REPORT
OF OCCUPATIONAL INJURY OR ILLNESS

Sedgwick CMS

P.O. Box 2065 – Oakland, CA. 94604-0065 Telephone (510) 302-3000 FAX No. (510) 302-3264

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.

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 telegram to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: **Foothill-De Anza Community College District**
1a. Policy Number: **FHDA-01**
Do not use this Column

2. MAILING ADDRESS (Number and Street, City, Zip): **12345 El Monte Road, Los Altos Hills, CA 94022**
2a. Phone Number: **(650) 949-6225**
CASE NUMBER

3. LOCATION, If different from Mailing Address (Number and Street, City and Zip)
3a. Location Code
OWNERSHIP

4. NATURE OF BUSINESS e.g. painting contractor, wholesale grocer, sawmill, hotel, etc.: **Education**
5. State Unemployment Insurance acct. no.
INDUSTRY

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

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. TIME INJURY/ILLNESS OCCURRED	9. TIME EMPLOYEE BEGAN WORK	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	SEX
	_____ AM _____ PM	_____ AM _____ PM		
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 ☐	AGE
15. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED" ☐ YES ☐ NO	16. SALARY BEING CONTINUED? ☐ YES ☐ NO	17. DATE OF EMPLOYERS KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE EMPLOEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)	DAILY HOURS

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, Tendonitis of left elbow, lead poisoning — DAYS PER WEEK

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)	20A. COUNTY	21. ON EMPLOYERS PREMISES? ☐ YES ☐ NO	WEEKLY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED. E.g. shipping department, machine shop		23. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ 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: — COUNTY

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

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. — PART OF BODY

27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, ZIP)	27a. Phone Number	SOURCE
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ Yes ☐ No If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, ZIP)	28a. Phone Number	
	29. Employee Treated in Emergency Room? ☐ Yes ☐ No	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.*

EMPLOYEE

30. EMPLOYEE NAME	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	SECONDARY SOURCE
33. HOME ADDRESS ((number and Street, City, Zip)		33a. PHONE NUMBER	
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 (check applicable status at time of injury. ☐ regular, full-time ☐ part-time ☐ student intern ☐ temporary ☐ seasonal	137b. Under what class code of your policy were wages assigned?	EXTENT OF INJURY
38. GROSS WAGES/SALARY $ _____ per _____	39. OTHER PAYMENT NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, lodging 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.