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

Please complete in triplicate (type if possible) Mail two copies to:
Submit via the online portal: https://wl.intercareins.com or submit to Disability Management via email WorkComp@sonoma-county.org or fax (707) 565-3501

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 Sonoma
1a. Policy Number: Self-Insured
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: N/A
6. TYPE OF EMPLOYER: Private State ✔ County City School District Other Gov't, Specify: _____

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)
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
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
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
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
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? No Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
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*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, 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: regular, full-time part-time temporary seasonal
37b. EMPLOYEE ID #
38. GROSS WAGES/SALARY: COMPLETED BY COUNTY PAYROLL AT INTERCARE'S REQUEST $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No COMPLETED BY COUNTY PAYROLL AT INTERCARE'S REQUEST

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

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

• 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.