

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

E M P L O Y E R	1. FIRM NAME UNIVERSITY OF CALIFORNIA – Office of the President		1A. DEPARTMENT	DO NOT USE THIS COLUMN	
	2. MAILING ADDRESS (Number and Street, City, Zip) 1111 Franklin Street 7th Floor, Oakland, CA 94607		2A. DEPARTMENT CODE	Case No.	
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, Zip)		3A. SUPERVISOR'S PHONE #	Ownership	
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. Education		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. 935-0503	Industry	
E M P L O Y E E	6. TYPE OF EMPLOYER <input type="checkbox"/> Private <input checked="" type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> School District <input type="checkbox"/> Other Government—Specify: _____			Occupation	
	7. EMPLOYEE NAME		8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm/dd/yy)	Sex
	10. HOME ADDRESS (Number and Street, City, Zip)		10A. PHONE NUMBER		Age
	11. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	12. OCCUPATION (Regular job title—NO initials, abbreviations or numbers)		13. DATE OF HIRE (mm/dd/yy)	Daily hours
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours		14A. EMPLOYMENT STATUS (Check applicable status at time of injury) ____ regular full-time ____ part-time ____ temporary ____ seasonal		14B. TITLE CODE	Days per week
15. GROSS WAGES/SALARY \$ _____ per _____		16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, lodging, overtime, bonuses, etc.) <input type="checkbox"/> Yes, \$ _____ per _____ <input type="checkbox"/> No		Weekly hours	
17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.	19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.	20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)	Weekly wage	
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		22. DATE LAST WORKED (mm/dd/yy)	23. DATE RETURNED TO WORK (mm/dd/yy)	24. IF STILL OFF WORK, CHECK THIS BOX <input type="checkbox"/>	County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No	27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)	28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)	Nature of injury
29. 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.				Part of body	
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)		30A. COUNTY	30B. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.			32. OTHER WORKERS INJURED/ILL IN THIS EVENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.				Sec. Source	
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.				Extent of Injury	
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 slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.					
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip)			36A. PHONE NUMBER		
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, Zip)			37A. PHONE NUMBER		
38. EMPLOYEE IDENTIFICATION NUMBER		38A. PAYROLL ACCOUNT—FUND—SUB		38B. EMPLOYEE WORK TELEPHONE NUMBER	
Completed by Supervisor		Signature		Title	Date