CLEAR PRINT

The Hanover Insurance Group®

State of California **EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**	Please complete in triplicate (type if possible) Mail two copies to:	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 orillness, 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		1a. Policy Number	Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number	CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code	OWNERSHIP
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct. no.	
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 _____	OCCUPATION
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	SEX
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 (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? ☐ Yes ☐ 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? ☐ Yes ☐ 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, State, zip)		27a. Phone Number	PART OF BODY
28. Hospitalized as an inpatient overnight? ☐ Yes ☐ No If Yes, then name and address of hospital (number, street, city, State, 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 possiblewhile 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, state, 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)	SECONDARY SOURCE
37. EMPLOYEE USUALLY WORKS _____ hours per day _____ hours 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	
38. GROSS WAGES/SALARY $ _____ per _____	39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No		EXTENT OF INJURY
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.