State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

York California

P.O. Box 619079, Roseville, CA 95661
(909) 608-7171 Fax: (866) 548-2637

OSHA Case No. _____

☐ Fatality

Any Person who makes or causes to be made any knowingly false or fraudulent 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.

EMPLOYER

1. FIRM NAME
1A. POLICY NUMBER
2. MAILING ADDRESS (Number, Street, City and 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.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

DO NOT USE THIS COLUMN
Case No.
Ownership
Industry
Occupation

INJURY OR ILLNESS

7. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
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 WAGES FOR DAY 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 EMPLOYEE CLAIM 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 of left elbow, lead poisoning.
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street and City)
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/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 INJURY/ILLNESS, eg., 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 and Zip)
27A. PHONE NUMBER
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ YES ☐ NO
IF YES THEN, NAME AND ADDRESS OF HOSPITAL (Number, Street, City and Zip)
28A. PHONE NUMBER
29. EMPLOYEE TREATED IN EMERGENCY Room? ☐ YES ☐ NO

Sex
Age
Daily hours
Days per week
Weekly Hours
Weekly wage
County
Nature of injury
Part of body
Source
Event
Sec. Source
Extent of injury

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)(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
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City and 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 ☐ temporary ☐ seasonal
37B. Under what class code of your policy were wages assigned?
38. GROSS WAGES/SALARY $_____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $_____ per _____ ☐ NO

*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.

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

FORM 5020 (REV. 7)
June 2002

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY