

State of California DEPARTMENT OF CORRECTIONS REPORT OF INMATE OCCUPATIONAL INJURY OR ILLNESS	STATE COMPENSATION INSURANCE FUND 24-Hour Claims Reporting Center Telephone: (888) 222-3211 Fax (800) 371-5905 THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE INMATE PAGE 1 of 2	OSHA Case No. <input type="checkbox"/> Fatality
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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 agencies 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 inmate subsequently dies as a result of a previously reported injury or illness, the agency 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.
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A G E N C Y	1. DEPARTMENT CDCR <input type="checkbox"/> CDF <input type="checkbox"/> PIA <input type="checkbox"/> IDL <input type="checkbox"/> OTHER <input type="checkbox"/>	1a. AGENCY CODE OR STATE FUND POLICY NUMBER	Please do not use this Column	
	2. MAILING ADDRESS (Number and Street, City, Zip)	2a. Phone Number		Case Number
	3. LOCATION, if different from Mailing Address (Number and Street, City, Zip)			Ownership
	4. NATURE OF BUSINESS Correctional Institutions	5. CDCR INSTITUTION		Industry
	6. TYPE OF AGENCY <input type="checkbox"/> PRIVATE <input checked="" type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> SCHOOL DIST. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____			Occupation

I N J U R Y O R I L L N E S	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. MILITARY TIME INJURY/ILLNESS OCCURRED	9. MILITARY TIME INMATE BEGAN WORK	10. IF INMATE DIED, DATE OF DEATH (mm/dd/yy)	Sex	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. DATE LAST WORKED (mm/dd/yy)	13. DATE RETURNED TO WORK <input type="checkbox"/> N/A (mm/dd/yy)	14. IF STILL OFF WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		Age
	15. NUMBER OF LAY IN DAYS AS A RESULT OF THIS INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	16. SALARY BEING CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	17. DATE OF AGENCY'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)	18. DATE INMATE WAS PROVIDED DWC 1 (mm/dd/yy)		Daily hours
	19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning.				19a. BODY PART AFFECTED	Days per Week
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)	20a. ZIP	20b. COUNTY	21. ON AGENCY'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	21a. WAS ANOTHER PERSON RESPONSIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	Weekly Hours
	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.	22a. Description/Title: Fire/Incident #	23. OTHER INDIVIDUALS INJURED OR ILL IN THIS EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Weekly Wage
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE INMATE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, pulaski, scaffold.					
	25. SPECIFIC ACTIVITY THE INMATE 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., Inmate 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, Zip or Institution)				27a. Phone Number	
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)				28a. Phone Number	Part of body	
				29. Inmate treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO		

ATTENTION: This form contains information relating to inmate health and must be used in a manner that protects the confidentiality of inmates 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 inmate information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

I N M A T E	30. INMATE NAME	30a. INMATE #	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	Source
	33. INMATE ADDRESS (HOME OR INSTITUTION)			33a. PHONE NUMBER	Event
	34. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		36. DATE INMATE ASSIGNED TO POSITION (mm/dd/yy)	Secondary Source
	37. INMATE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours	37a. ESTIMATE PAROLE RELEASE DATE		37b. DATE OF INCARCERATION	
	38. GROSS WAGES/SALARY \$ _____ per _____				Extent of Injury
Completed By (type or print)		Signature	Inmate Supervisor (type or print)	Phone	Date (mm/dd/yy)

* Confidential information may be disclosed only to the inmate, former inmate, 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 agency (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

Complete the following questions as accurately as possible to the best of your knowledge, but do not delay submission of this form to State Fund.
THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE INMATE.

PAGE 2 of 2

INMATE'S NAME	INMATE #	INMATE'S ASSIGNED BASE CAMP	
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39. AGENCY REPRESENTATIVE CONTACT INFORMATION (WHO IS THE BEST PERSON TO PROVIDE ADDITIONAL INFORMATION REGARDING THIS CLAIM?) (Full Name, Title, Phone #, Email Address)

40. WERE THERE ANY WITNESSES TO THE ALLEGED INCIDENT OR INJURY? YES NO UNKNOWN

IF YES, WHAT IS THE WITNESS CONTACT INFORMATION? (Full Name, Title)
State Fund: Please contact agency representative in 39, above, to coordinate discussions with any/all witnesses listed below.

41. WAS THE INJURY CAUSED BY ANOTHER PERSON, A THIRD PARTY OR DEFECTIVE EQUIPMENT? YES NO UNKNOWN

42. ARE YOU AWARE OF THE INMATE HAVING GAINFUL EMPLOYMENT PRIOR TO INCARCERATION? YES NO UNKNOWN

43. ARE THERE ANY DISPUTES REGARDING THE INJURY? YES NO UNKNOWN

44. WAS THE INMATE TRANSFERRED TO AN INSTITUTION AS THE RESULT OF THIS INJURY/ILLNESS? YES NO

45. LIABILITY MATRIX INFORMATION (PLEASE CHECK THE WORK BEING PERFORMED AT THE TIME OF THE INJURY/ILLNESS – **SELECT ONE**)

- FEDERAL RESPONSIBILITY AREA FIRE (IF THIS ITEM IS CHECKED, PLEASE PROVIDE INCIDENT # _____)
- STATE RESPONSIBILITY AREA FIRE (IF THIS ITEM IS CHECKED, PLEASE PROVIDE INCIDENT # _____)
- LOCAL RESPONSIBILITY AREA FIRE (IF THIS ITEM IS CHECKED, PLEASE PROVIDE INCIDENT # _____)
- FIRE TRAINING AT A FORESTRY TRAINING CENTER (FTC) LOCATION
- FIRE TRAINING AT ANY LOCATION OTHER THAN A FTC
- WORK PROJECT
- NO WORK BEING PERFORMED AT TIME OF REPORTING INJURY/ILLNESS
- UNKNOWN AT THIS TIME; NEED SUPERVISORY ASSISTANCE TO DETERMINE
- OTHER; PLEASE DESCRIBE: _____

46. IS THERE ANY ADDITIONAL FACTUAL INFORMATION RELEVANT TO THIS CLAIM?