

<b>State of California</b> <b>DEPARTMENT OF STATE HOSPITALS REPORT OF PATIENT WORKER OCCUPATIONAL INJURY OR ILLNESS</b>	<b>STATE COMPENSATION INSURANCE FUND</b> 24-Hour Claims Reporting Center Telephone: (888) 222-3211 Fax (800) 371-5905 <b>THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE PATIENT WORKER</b> <b>PAGE 1 of 2</b>	<b>OSHA Case No.</b>  <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 <b>five days</b> of knowledge every occupational injury or illness which results in lost time beyond the date of the incident <b>OR</b> requires medical treatment beyond first aid. If a patient worker subsequently dies as a result of a previously reported injury or illness, the agency must file within <b>five days</b> of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be <b>reported immediately</b> by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.
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<b>A G E N C Y</b>	1. DEPARTMENT DSH <input checked="" 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; State Hospitals	5. DSH 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

<b>I N J U R Y  O R  I L L N E S S</b>	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)	8. MILITARY TIME INJURY/ILLNESS OCCURRED	9. MILITARY TIME PATIENT WORKER BEGAN WORK	10. IF PATIENT WORKER 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 DAYS AWAY FROM WORK AS A RESULT OF THIS INJURY	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 PATIENT WORKER 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. Serious Incident Report #	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 PATIENT WORKER WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., lawn mower, haircutting shear.					
	25. SPECIFIC ACTIVITY THE PATIENT WORKER WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., trimming hedges, mopping floors, loading boxes onto truck.					
	26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Patient 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 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. Patient worker treated in Emergency Room? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

<b>P A T I E N T  W O R K E R</b>	30. PATIENT WORKER NAME	30a. PATIENT WORKER #	31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yy)	Source	
	33. PATIENT WORKER 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 PATIENT WORKER ASSIGNED TO POSITION (mm/dd/yy)		Secondary Source
	37. PATIENT WORKER USUALLY WORKS _____ hours per day    _____ days per week    _____ total weekly hours		37a. ESTIMATE DISCHARGE DATE	37b. DATE OF ADMISSION		
	38. GROSS WAGES/SALARY \$ _____ per _____					Extent of Injury
Completed By (type or print)		Signature	Patient Worker Supervisor (type or print)	Phone	Date (mm/dd/yy)	

\* Confidential information may be disclosed only to the patient worker, former patient worker, 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 PATIENT WORKER.

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PATIENT WORKER'S NAME	PATIENT WORKER #	PATIENT WORKER'S ASSIGNED HOSPITAL FACILITY	UNIT #
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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. IS A CONSERVATOR APPOINTED BY THE COURT?  YES  NO  UNKNOWN

IF YES, PROVIDE CONSERVATOR NAME AND CONTACT INFORMATION.  STATE  INDIVIDUAL

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

41. 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.**

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

43. ARE YOU AWARE OF THE PATIENT WORKER HAVING GAINFUL EMPLOYMENT PRIOR TO ADMISSION?  YES  NO  UNKNOWN

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

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

VOCATIONAL REHABILITATION PROGRAM WORK ASSIGNMENT

SHELTERED WORKSHOP WORK ASSIGNMENT

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?