

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness, send **TWO** copies of this report to the **employer's workers' compensation insurance carrier** or the **self-insured employer**. Failure to file a timely doctor's report may result in assessment of a civil penalty. **In the case of diagnosed or suspected pesticide poisoning**, send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS						PLEASE DO NOT USE THIS COLUMN		
2. EMPLOYER NAME						Case No.		
3. Address:		No. and Street		City		Zip	Industry	
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)						County		
5. PATIENT NAME (First name, middle initial, last name)				6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth Mo. Day Yr.		Age
8. Address:		No. and Street		City		9. Telephone Number ()		Hazard
10. Occupation (Specific job title)						11. Social Security Number - - -		Disease
12. Injured at:		No. and Street		City		County		Hospitalization
13. Date and hour of injury or onset of illness		Mo. Day Yr.		Hour _____ a.m. _____ p.m.		14. Date last worked Mo. Day Yr.		Occupation
15. Date and hour of first examination or treatment		Mo. Day Yr.		Hour _____ a.m. _____ p.m.		16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if none or pending.)

20. DIAGNOSIS (if occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? Yes No

ICD-9 Code _____

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? Yes No If "yes", please explain.

23. TREATMENT RENDERED (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan / estimated duration.

25. If hospitalized as inpatient, give hospital name and location. Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS Is patient able to perform usual work? Yes No

If "no", date patient can return to: Regular work ____/____/____

Modified work ____/____/____ Specify restrictions _____

Doctor's Signature _____ Date _____

CA License Number _____

Doctor Name and Degree (Please Type) _____

IRS Number _____

Address _____

Telephone Number (_____) _____

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.