CLEAR FORM

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

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.

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.

AGENCY

1. DEPARTMENT CDCR ☐ CDF ☐ PIA ☐ IDL ☐ OTHER ☐
1a. AGENCY CODE OR STATE FUND POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
3. LOCATION, if different from Mailing Address (Number and Street, City, Zip)
4. NATURE OF BUSINESS Correctional Institutions
5. CDCR INSTITUTION
6. TYPE OF AGENCY
☐ PRIVATE ☒ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

INJURY OR ILLNESS

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)
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 ☐ N/A (mm/dd/yy)
14. IF STILL OFF WORK ☐ YES ☐ NO
15. NUMBER OF LAY IN DAYS AS A RESULT OF THIS INJURY ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO ☐ 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)
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
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)
20a. ZIP
20b. COUNTY
21. ON AGENCY'S PREMISES? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
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? ☐ YES ☐ NO
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.
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.
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip or Institution)
27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
29. Inmate treated in Emergency Room? ☐ YES ☐ 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.*

INMATE

30. INMATE NAME
30a. INMATE #
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. INMATE ADDRESS (HOME OR INSTITUTION)
33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE INMATE ASSIGNED TO POSITION (mm/dd/yy)
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 _____

Completed By (type or print)	Signature	Inmate Supervisor (type or print)	Phone	Date (mm/dd/yy)

Please do not use this Column
Case Number
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per Week
Weekly Hours
Weekly Wage
County
Nature of Injury
Part of body
Source
Event
Secondary Source
Extent of Injury

* 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.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INMATE WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.

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.
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INMATE'S NAME	INMATE #	INMATE'S ASSIGNED BASE CAMP	

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?