CLEAR FORM

State of California

DEPARTMENT OF STATE HOSPITALS REPORT OF PATIENT WORKER 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 PATIENT WORKER

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 a patient worker 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 DSH [X]
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; State Hospitals
5. DSH INSTITUTION
6. TYPE OF AGENCY
☐ PRIVATE [X] 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 PATIENT WORKER BEGAN WORK
10. IF PATIENT WORKER 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 DAYS AWAY FROM WORK AS A RESULT OF THIS INJURY
16. SALARY BEING CONTINUED? ☐ YES ☐ NO ☐ 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)
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. Serious Incident Report #
23. OTHER INDIVIDUALS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO
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? ☐ NO ☐ YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)
28a. Phone Number
29. Patient worker treated in Emergency Room? ☐ YES ☐ 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.*

PATIENT WORKER

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

Completed By (type or print)	Signature	Patient Worker 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 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.

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE PATIENT WORKER 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.
THIS FORM IS NOT TO BE VIEWED OR COMPLETED BY THE PATIENT WORKER.

PATIENT WORKER'S NAME	PATIENT WORKER #	PATIENT WORKER'S ASSIGNED HOSPITAL FACILITY	UNIT #

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?