STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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 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 the report to Department of Industrial Relations, 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:

2. Employer Name:

3. Address: No. and Street: | City: | Zip Code:

4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.):

5. Patient Name (first Name, middle initial, last name): | 6. Sex: | 7. Date of Birth:

8. Address No. and Street: | City: | Zip Code: | 9. Phone Number:

10. Occupation (Specific job title): | 11. Social Security Number: | 12. Date and hour of injury or onset of illness:

13. Address No. and Street Where Injury Occurred: | City Where Injury Occurred: | Country:

14. Date last worked: | 15. Date and hour or 1st exam or treatment:

16. Have you or your office previously rendered treatment:

Patient please complete this portion, if able to do so. Otherwise, doctor 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:**

19. **Objective Findings:**

A. Physical Examination:

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