



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 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 Date: Mo. Day Yr.	
8. Address			No. and Street	City	Zip
10. Occupation (Specific job title)			9. Telephone number ()		Hazard
12. Injured at:			11. Social Security Number - -		Disease
12. Injured at:	No. and Street	City	County		Hospitalization
13. Date and hour of injury or onset of illness			14. Date last worked		Occupation
Date: Mo. Day Yr. Hour: _____			Date: Mo. Day Yr.		
15. Date and hour of first examination or treatment			16. Have you (or your office) previously treated patient?		Return Date/Code
Date: Mo. Day Yr. Hour: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		
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 non or pending.)					
20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-9 Code _____ - _____					
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please explain.					
22. Is there any other current condition that will impede or delay patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", date when patient can return to: Regular work ___/___/___ Modified work ___/___/___ Specify restrictions _____					

Doctor's Signature _____ 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.