STATE OF CALIFORNIA
CAL OSHA
Department of Industrial Relations

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

Case No.

2. EMPLOYER NAME

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 ☐ Male ☐ Female

7. Date of Birth **Date:** Mo. Day Yr.

Age

8. Address **No. and Street** **City** **Zip**

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
Date: Mo. Day Yr. **Hour:** _____ ☐ a.m. ☐ p.m.

14. Date last worked
Date: Mo. Day Yr.

Occupation

15. Date and hour of first examination or treatment
Date: Mo. Day Yr. **Hour:** _____ ☐ a.m. ☐ p.m.

16. Have you (or your office) previously treated patient? ☐ Yes ☐ 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 non 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 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.

FORM 5021 (Rev. 4)
1992