

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 Male Female		7. Date of Birth. Mo. Day Yr.	
8. Address: No. and Street		City	Zip	9. Telephone number ()	
10. Occupation (Specific job title)				11. Social Security Number	
12. Injured at:		No. and Street	City	County	
13. Date and hour of injury or onset of illness		Mo. Day Yr.	Hour a.m. p.m.	14. Date last worked Mo. Day Yr.	
15. Date and hour of first examination or treatment		Mo. Day Yr.	Hour a.m. p.m.	16. Have you (or your office) previously treated patient? Yes 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? Yes No ICD-9 Code _____					
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illnesses 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 benefit or payments is guilty of a felony