

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
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)			Industry
5. PATIENT NAME (first name, middle initial, last name)			Age
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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			Hospitalization
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. Occupation
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <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 (____) _____	