

# 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 self-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 this 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.

<b>1. INSURER NAME AND ADDRESS</b>				<b>PLEASE DO NOT USE THIS COLUMN</b>	
<b>2. EMPLOYER NAME</b>				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. <b>PATIENT NAME</b> (first name, middle initial, last name)			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.	
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	
<p><b>Patient please complete this portion, if able to do so.</b> 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.</p> <p><b>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED</b> (Give specific object, machinery or chemical. Use reverse side if more space is required.)</p>					

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 none 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 hospitalization 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 \_\_\_\_\_