

# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

## STATE OF CALIFORNIA

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 420503, San Francisco CA 94142-0503, 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 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
13. Date and hour of injury or onset of illness		No. and Street	City	County
15. Date and hour of first examination or treatment		14. Date last worked Mo. Day Yr.		Hospitalization
16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Describe how the accident or exposure happened (Give specific object, machinery or chemical. Use reverse side if more space is required.)		Occupation
18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)		19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)		

I have not violated Labor Code Section 139.3 and the contents of this report and bill is true and correct to the best of my knowledge. This statement is made under penalty of perjury.

DATE OF REPORT \_\_\_\_\_  
 Dated this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_  
 at \_\_\_\_\_ County, California.

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 Mo. Day Yr. Estimated stay admitted

26. WORK STATUS Is patient able to perform usual work?  Yes  No  
 If "no", date patient can return to: Regular work \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Modified work \_\_\_\_/\_\_\_\_/\_\_\_\_ Specify restrictions \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_ 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.**