FILL OUT AND FORWARD 1 COPY IMMEDIATELY AFTER FIRST SEEING PATIENT

# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

## LODI MEMORIAL HOSPITAL

CALL BOX 3004 — LODI, CALIFORNIA 95240

**ALSO, Immediately after first examination mail one copy directly to the Division of Labor Statistics and Research, P. O. Box 965, San Francisco 94101**
Failure to file a report with the Division is a misdemeanor. (Labor Code, Section 6413.5)
**Answer all questions fully.**

Do not write in this space

1. **EMPLOYER** S.J. Mosquito Abatement
2. Address (No., St. & City) _____
3. Business (Manufacturing shoes, building construction, retailing men's clothes, etc.) _____

SOCIAL SECURITY NO. [redacted]

4. **EMPLOYEE** (First name, middle initial, last name) Donald Meidinger
5. Address (No., St. & City) [redacted] Zip 95237
6. Occupation _____ Age 37 Sex M
7. Date injured 12-4-90 Hour _____ M Date last worked 12-4-90
8. Injured at (No., St. & City) Job Location County San Joaquin
9. Date of your first examination 12-4-90 Hour 8:22 M Who engaged your services? Self
10. Name other doctors who treated employee for this injury _____

**ACCIDENT OR EXPOSURE:** Did employee notify employer of this injury? _____ Employee's statement of cause of injury or illness:

12. **NATURE AND EXTENT OF INJURY OR DISEASE** (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposures.)

Lt Eye pain

Foreign body to Lt cornea

13. X-rays: By whom taken? (State if none) none
Findings:

14. Treatment: exam/ fluorescein/ antibiotic / Eye patch/ analgesic

15. Kind of case (Office, home, or hospital) _____ If hospitalized, date _____ Estimated stay _____
Name and address of hospital _____
16. Further treatment (Estimated frequency and duration) Dr Berlin in 1/52
17. Estimated period of disability for: Regular work 1d Modified work 2d
18. Describe any permanent disability or disfigurement expected (State if none) _____
19. If death ensued, give date _____

20. **REMARKS** (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

RECEIVED
MAR 5 1991

N. B.—ONLY UNDER EXCEPTIONAL CIRCUMSTANCES WILL A HERNIA BE CONSIDERED DISABLING PRIOR TO OPERATION. THE INJURED eye 12-4-90 ADVISED TO CONTINUE WORK, IF POSSIBLE, UNTIL NOTIFIED THAT HIS CLAIM IS ACCEPTED.

Name _____ Degree _____ [ PERSONAL SIGNATURE OF DOCTOR ] _____
(Type or print)

Date of report _____ Address (No., St. & City) _____ ZIP _____ Tel. No. _____

7230-07

*Use reverse side if more space required*