State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

ACCLAMATION INSURANCE MANAGEMENT SERVICES
209-227-0801
P.O. Box 28169
FRESNO, CA 93729

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: SAN JOAQUIN CO. MOSQUITO & VECTOR CONTROL DISTRICT
1a. Policy Number:
Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip): 7759 SOUTH AIRPORT WAY STOCKTON CA 95206
2a. Phone Number: 209 982-4675
CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip):
3a. Location Code:
OWNERSHIP
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: MOSQUITO CONTROL
5. State unemployment insurance acct.no:
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☒ Other Gov't, Specify: Special Dist.
INDUSTRY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 1/21/05
8. TIME INJURY/ILLNESS OCCURRED: ____ AM 12:__ PM
9. TIME EMPLOYEE BEGAN WORK: 7:30 AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy):
OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☒ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy): 1/25/05
13. DATE RETURNED TO WORK (mm/dd/yy):
14. IF STILL OFF WORK, CHECK THIS BOX: X
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☒ Yes ☐ No
16. SALARY BEING CONTINUED? ☒ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 1/25/05
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy): 1/26/05
SEX
AGE
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Rash all over body
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): District yard
20a. COUNTY: San Joaquin
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: yard area
23. Other Workers injured or ill in this event? ☐ Yes ☒ No
DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold: weeds
WEEKLY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.: Standing and jumping on the weeds to pack them down in garbage dumpster.
WEEKLY WAGE
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY: same as above
COUNTY
27. Name and address of physician (number, street, city, zip): Dr. Rossman Dameron Occupational Health Services 525 W Acacia St Stockton CA 95203
27a. Phone Number: 209 461-3196 #3
NATURE OF INJURY
28. Hospitalized as an inpatient overnight? ☒ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number:
29. Employee treated in emergency room? ☐ Yes ☐ No
PART OF BODY
SOURCE

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Tiffany Anderson
31. SOCIAL SECURITY NUMBER: 549-23-5133
32. DATE OF BIRTH (mm/dd/yy): 08/22/70
EVENT
33. HOME ADDRESS (Number, Street, City, Zip): 1830 S Hutchins #304 Lodi CA 95240
33a. PHONE NUMBER: 209 333-1037
SECONDARY SOURCE
34. SEX ☐ Male ☒ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Mosquito Technician I
36. DATE OF HIRE (mm/dd/yy): 4/19/04
37. EMPLOYEE USUALLY WORKS 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED: salaries/wages
EXTENT OF INJURY
38. GROSS WAGES/SALARY: $ 1421. per bi-weekly
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☒ No

Completed By (type or print): Carol Aksland
Signature & Title: Carol Aksland
Date (mm/dd/yy): 1-26-05

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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