DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

BURNETS TO SOFT PRINTED TO STORY OF SHORE THE CONTRACTOR

Occupational Injury Clinic

20 W. Acacia Street , STE # 2 Linacia 1st Flouries

Stockton, CA 95204-



Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's 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 case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420803, San Francisco. CA 94142-0603, and notify your local health officer by telephone within 24-hours.

1. INSURED NAME AND ADDRESS

PLEASE DO NOT

1. INSURED NAME AND AD	DRESS					PLEASE DO NO
AIMS - Fresno 804	6 PO Box 28100	O, Fresno, CA	93729			USE THIS COLUMN
2. EMPLOYER NAME						Case no
SJ Mosquito and Ve	ctor Control					Ouse no
3. Address	No. and Street			City	Zip	Industry
7759 S Airport Way			Sto	ckton	95206	andustry
4. Nature of Business (e.g., to		construction, retailer of v		CKCOII	33206	County
	3,	out of the second of the secon	Women's ciotiles/			County
5. PATIENT NAME						
Anderson, Tiffany	v .		6. Sex [] Male	[X] Fernale	7. Date of Mo. Day Yea	
8. Address		CI.			08/22/19/0	
1416 Iris Dr #7	No. and Street	City	Zip	9. Telephone		Hazard
10. Occupation (Specific Job ti	(Ia)	Lodi	95242	(209) 3	333-1037	
	ne)			11. Social Ser	curity Number	Disease
Tech I 12. Injured at:	N. J. Gi			549-23-	5133	
WORK PLACE	No. and Street		City	County		Hospitalization
		. STO	OCKTON	SAN JOAC	NIU	
13. Date and hour of injury	Mo. Day Yr.	Hour		14. Date Last	Worked Mo. Day Yr.	Occupation
or onset of illness	10/11/2005	09:00 am				
15. Date and hour of first	Mo. Day Yr.	Hour		16. Have you	or your office) previously	Return Date/Code
examination or treatment	10/13/2005			treated no	licato I I Van IVI Na	
Patient please complete this his/her rights to workers' compe	portion, if able to do so. C	therwise, doctor please	complete immediate	ely Inability or failur	lient? [] Yes [X] No e of a patient to complete this portion	
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