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State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

- ☐ P.O. Box 5372, Walnut Creek, CA 94596 — Tel (925) 933-2992 FAX (925) 933-2994
- ☐ P.O. Box 1406, Roseville, CA 95678 — Tel (916) 783-0100 FAX (916) 783-0335
- ☐ P.O. Box 491749, Redding, CA 96049-1749 — Tel (530) 223-2574 FAX (530) 223-2679

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.

NOTICE: 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: Tiffany Anderson
1A. POLICY NUMBER
DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP): 1830 S Hutchins #304 Lodi CA 95240
2A. PHONE NUMBER: 333-9249
Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
Industry
Occupation
6. TYPE OF EMPLOYER: ☐ PRIVATE ☐ STATE ☐ CITY ☒ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME: Tiffany Anderson
8. SOCIAL SECURITY NUMBER: 549-23-5133
9. DATE OF BIRTH (mm/dd/yy): 8-22-70
Sex
10. HOME ADDRESS (Number and Street, City, ZIP): 1830 S. Hutchins #304 Lodi CA 95240
10A. PHONE NUMBER: 333-9249
Age
11. SEX: ☐ MALE ☒ FEMALE
12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
13. DATE OF HIRE (mm/dd/yy)
Daily hours
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury): ____ regular full-time ____ part-time ____ temporary ____ seasonal
14B. Under what class code of your policy were wages assigned?
Days per week
15. GROSS WAGES/SALARY: $_____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $_____ per _____ ☐ NO
Weekly hours
Weekly wage

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. TIME INJURY/ILLNESS OCCURRED: _____ A.M. 1 (P.M.)
19. TIME EMPLOYEE BEGAN WORK: 7 (A.M.) _____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
County
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☒ NO
22. DATE LAST WORKED (mm/dd/yy)
23. DATE RETURNED TO WORK (mm/dd/yy)
24. IF STILL OFF WORK CHECK THIS BOX ☐
Nature of injury
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)
Part of body
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.: rash over all body
Source
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City): McGurk Property
30A. COUNTY: SJ
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
Event
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
Sec. Source
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene welding torch, farm tractor, scaffold.: weeds
Extent of Injury
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.: checking sources.
35. 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.: walking through brush looking for mosquito source came in contact with poison oak
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

Completed by (type or print)	Signature	Title	Date

FORM 5020 (REV. 6)