Print Form

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Reset Form

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 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 the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address

2. Employer Name

3. Address No. and Street | City | Zip Code

4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)

5. Patient Name (first Name, middle initial , last name) | 6. Sex | 7. Date of Birth

8. Address No. and Street | City | Zip Code | 9.Phone Number

10. Occupation (Specific job title) | 11. Social Security Number | 12. Address No.& Street Where Inj. Occurred

City Where Injury Occ. | County | 13. Date and hour of injury or onset of illness

14. Date last worked | 15. Date and hour of 1st exam or treatment | 16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **Describe how the accident or exposure happened.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS**

19. O**bjective Findings**

A. Physical Examination

B. X-ray and laboratory results (State if none or pending.)

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20. **DIAGNOSES**(if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?

1. _____ ICD-10 _____
2. _____ ICD-10 _____
3. _____ ICD-10 _____
4. _____ ICD-10 _____
5. _____ ICD-10 _____
6. _____ ICD-10 _____
7. _____ ICD-10 _____
8. _____ ICD-10 _____
9. _____ ICD-10 _____
10. _____ ICD-10 _____
11. _____ ICD-10 _____
12. _____ ICD-10 _____

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? If "no," please explain below:

22. Is there any other current condition that will impede or delay patient's recovery? If "yes," please explain below:

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 admitted Estimated length of stay

26. WORK STATUS - Is patient able to perform usual work? ☐ Yes ☐ No

If "no", date when patient can return to Regular work Modified work

Specify restrictions

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Physician Signature: *(original signature, do not stamp)*

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature _____ Cal. License Number: _____

Executed at: _____ Date *(mm/dd/yyyy)*: _____

Physician Name _____ Specialty: _____

Physician address: _____ Phone Number _____

Any person who makes or causes to be made any knowingly fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PRIVACY NOTICE: The Administrative Director is authorized to maintain the records of the Division of Workers' Compensation (DWC). (Cal. Lab. Code § 126.) The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide this notice to individuals who submit information to the DWC pertaining to a workers' compensation claim. (Cal. Civ. Code § 1798.17; Public Law 93-579.)

The principal purpose for requesting information from injured workers, dependents, lien claimants, physician, employers or their representatives is to administer the California workers' compensation system. Each form shows which fields are required to be completed for DWC to process the form. If a required field in a form is incomplete or unreadable, the DWC may return the form to the individual for correction or may reject the form. Providing a social security number is required on this form pursuant to Labor Code § 6409. If you do not provide your security number, the DWC may return the form to you for correction or reject the form. If you do not have a social security number, indicate this in the space provided for the injured worker's social security number. As permitted by law, social security numbers are used to help properly identify injured workers and to conduct statistical research as allowed under the Labor Code.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records. (Cal. Civ. Code §§ 1798.34-1798.3.) You may request a copy of the DWC's policies and procedures for inspection of records at the address below. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Cal. Civ. Code § 1798.33.) Requests should be sent to: Division of Workers' Compensation- Medical Unit, P.O. Box 71010, Oakland, CA 94612. Tel: (510) 286-3700 or (800) 794.6900. Fax: (510) 622-3467.