**EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

**State of California**

**EMPLOYER**
- **Firm Name**: Stanford University
- **Mailing Address**: 215 Panama Street, Building D, Stanford, CA 94305-6207
- **Location Code**: 3a.

**FATALLY**

**NOTE**: This form contains information relating to employee health and must be used in a manner that protects confidentiality to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.30. CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

**CLAIMS ADMINISTRATOR**: American Zurich Insurance Company, P.O. Box 968002, Schaumburg, IL 60196-8002

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.

**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.**

**E X P O S U R E**

**INJURY OR ILLNESS**

**DATE OF INJURY / ONSET OF ILLNESS** (mm/dd/yy)
- **Time Injury/Illness Occurred**
  - **AM**
  - **PM**

**Event or Exposure Occurred**
- **Location Where Event or Exposure Occurred**
  - **Number, Street, City, Zip**
  - **County**
  - **City**
  - **School District**
  - **Other Gov't Industry:**

**Time Employee Began Work**
- **AM**
- **PM**

**TIME LAST WORKED (mm/dd/yy)**
- **Date Last Worked**
- **Time Employee Injured or Ill**

**PAYMENTS**
- **Gross Wages/Salary**
  - **$** per
- **Claim Dates**
  - **Date**

**SIGNATURE & TITLE**
- **Completed By**
  - **(type or print)**
  - **Signature & Title**
  - **Date (mm/dd/yy)**

**OTHER Documentation Required**
- **OCCUPATION**
  - **Full Time**
  - **Part Time**
  - **Temporary**
  - **Seasonal**

**EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY OR ILLNESS**
- **Nature of Business**
  - **Painting contractor, wholesale grocer, sawmill, hotel, etc.**

**SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED**
- **Welding seams of metal forms, loading boxes onto truck.**

**SPECIFIC INJURY/IllNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS**
- **Second degree burns on right arm, tendinitis on left elbow, lead poisoning**

**NOTE**: Shaded boxes indicate confidential employee information as listed in 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.