PATIENT'S FIRST REPORT OF WORK INJURY/ILLNESS
STATE OF CALIFORNIA

	PLEASE DO NOT USE THIS COLUMN
1. **INSURER NAME AND ADDRESS**	
2. **EMPLOYER NAME**	Case No.
3. Address: No. and Street City Zip	Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)	County
5. **PATIENT NAME** (First name, middle initial, last name) / 6. Sex ☐ Male ☐ Female / 7. Date of Birth Mo. Day Yr.	Age
8. Address: No. and Street City Zip / 9. Telephone Number ( )	Hazard
10. Occupation (Specific job title) / 11. Social Security Number – –	Disease
12. Injured at: No. and Street City County	Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _______ a.m. _______ p.m. / 14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment Mo. Day Yr. Hour _______ a.m. _______ p.m. / 16. Have you (or your office) previously treated patient? ☐ Yes ☐ No	Return Date/Code

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.)

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.

SAMPLE

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