State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

MUST BE TYPED. RETURN ORIGINAL TO: Risk Management MC 6207

Stanford University
Risk Management
215 Panama Street, Building D
Stanford, CA 94305-6207

Claims Administrator:
Zurich North America Claims
PO Box 968002
Schaumburg IL 60196-8002

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 worker's 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 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: **Stanford University**
1A. POLICY NUMBER: **WC-8298452**
DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP): **Stanford, CA 94305**
2A. PHONE NUMBER
Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP): ☐**University** ☐**SLAC**
3A. LOCATION CODE
Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.: **Education/ Research**
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
Industry
6. TYPE OF EMPLOYER: ☒PRIVATE
Occupation

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm/dd/yy)
Sex
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
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 p/day days p/week total weekly hrs.
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
14C. DEPARTMENT
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

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. TIME INJURY/ILLNESS OCCURRED A.M. P.M.
19. TIME EMPLOYEE BEGAN WORK A.M. P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
Weekly wage
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 ☐
County
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)
Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendentious of left elbow, lead poisoning.
Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐YES ☐NO
Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐YES ☐NO
Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
Extent of injury
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.
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
38. TO WHOM INJURY WAS REPORTED

Completed by (type or print)	Phone Number (area code)	Signature	Title	Date