




## Instructions for Completing Form 5020 Employer's Report of Occupational Injury

Please fill out each line completely, in order to expedite setting up this claim account. **PLEASE PRINT CLEARLY.**

- Line 1 Enter Employer Name 1a. Enter Policy Number (Please refer to your policy.)
- Line 2 Enter Employer Mailing Address 2a. Enter Phone w/ Area Code
- Line 3 Enter Employer Location, if different 3a. Enter Dept. Number, for Employee. This may be your payroll job classification code.
- Line 4 Enter Employer Nature of Business
- Line 5 Enter Employer State Unemployment Insurance Account Number
- Line 6 Check Type of Employer Box
- Line 7 Enter Date of Employee Injury
- Line 8 Enter Time of Injury, if known.
- Line 9 Enter Time of Day, Employee Began Work (On day of injury.)
- Line 10 If applicable; Enter Date of Death
- Line 11 Indicate if Employee was able to Work One-Full AFTER Date of Injury
- Line 12 Enter Last Date Employee Worked.
- Line 13 Enter Date Employee Returned to Work
- Line 14 Check if, Employee is Still Off Work
- Line 15 Indicate if Employee was Paid Full Wages on Date of Injury or Last Day Worked.
- Line 16 Indicate if Employee Salary is Still Being Paid
- Line 17 Enter Date of Employer's Knowledge of Injury/ Illness
- Line 18 Enter Date Employee was Provided DWC-1 Claim Form
- Line 19 Enter Employee's Injury/ Illness and Part of Body Effected or Medial Diagnosis
- Line 20 Enter Location Employee Injury Occurred 20a. Enter County of Location
- Line 21 Indicate if On Employer's Premises
- Line 22 Enter Department Where Injury/ Exposure Occurred, if applicable
- Line 23 Indicate if Other Employee's were Injured/ Ill, in this Event
- Line 24 Enter Equipment, Material or Chemicals Involved with Injury/ Illness, if applicable
- Line 25 Enter Activity Employee was Performing, in this Event
- Line 26 Enter How Injury/ Illness Occurred. Describe Exposure, Materials and Sequence of Events, that Produced Injury/ Illness.
- Line 27 Enter Physician Name and Address 27a. Enter Physician Phone, if known
- Line 28 Enter Hospital Name and Address, if applicable 28a. Enter Hospital Phone, if known
- Line 29 Indicate if Employee was Treated in Emergency Room
- Line 30 Enter Employee Name, include Middle Initial
- Line 31 Enter Employee Social Security Number
- Line 32 Enter Employee Date of Birth
- Line 33 Enter Employee Address 33a. Enter Employee Phone w/ Area Code (Please verify Address and Phone w/ Employee)
- Line 34 Check Employee Gender Box
- Line 35 Enter Employee Job Title
- Line 36 Enter Employee Date of Hire
- Line 37 Enter Employee Usual Hours Worked Per Day, Days Worked Per Week and Total Weekly Hours. 37a. Enter Employee Status (At time of injury.) 37b. Enter Employee Payroll Job Class Code, in which Earnings are assigned.
- Line 38 Enter Employee Salary per Occurrence (Hourly, bi-monthly, monthly, or annually)
- Line 39 Enter Other Employee Payments Not Reported as Salary, if applicable

At the bottom of this form, print Name and Title of Individual who is filing The Injury Report. Date and Sign form, keeping PINK COPIES for Employer File and mail WHITE COPIES to your Intercare Insurance Claims Office.

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail two copies to: <b>INTERCARE INSURANCE SERVICES</b> P.O. Box 579 Roseville, CA 95661 Intercare 1 (800) 771-5454 FAX 1 (877) 362-5050			OSHA CASE NO.  FATALITY <input type="checkbox"/>	
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.		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 <b>Ernestine's Engine Repair</b>		1a. Policy Number <b>RSR001763</b>		Please do not use this Column	
	2. MAILING ADDRESS: (Number, Street, City, Zip) <b>17423 Tailor Lane, West Honor Oaks, CA 91609</b>		2a. Phone Number <b>(555) 614-2311</b>		CASE NUMBER	
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		OWNERSHIP	
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc. <b>automotive repair</b>		5. State unemployment insurance acct. no. <b>CALIF.</b>		INDUSTRY	
	6. TYPE OF EMPLOYER: <input checked="" type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Govt, Specify:		7. DATE OF INJURY / ONSET OF ILLNESS (mm / dd / yy) <b>7/14/02</b>		8. TIME INJURY/ILLNESS OCCURRED <b>8:30 AM</b> _____ PM	
	11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		12. DATE LAST WORKED (mm / dd / yy) <b>7/14/02</b>		9. TIME EMPLOYEE BEGAN WORK <b>7:00 AM</b> _____ PM	
	15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10. IF EMPLOYEE DIED, DATE OF DEATH (mm / dd / yy)	
	17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm / dd / yy) <b>7/14/02</b>		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy) <b>7/15/02</b>		13. DATE RETURNED TO WORK (mm / dd / yy)	
	14. IF STILL OFF WORK, CHECK THIS BOX: <input checked="" type="checkbox"/>		19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available; e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning <b>Broken wrist (left)</b>		14. IF STILL OFF WORK, CHECK THIS BOX: <input checked="" type="checkbox"/>	
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip) <b>17423 Tailor Lane, W. Honor Oaks 91609</b>		20a. COUNTY <b>Canada</b>		21. ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
EMPLOYEE	22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop. <b>auto repair shop</b>		23. Other Workers Injured/ill in this event? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		DAILY HOURS	
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene welding torch, farm tractor, sawdust <b>wrench</b>		25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck <b>working with wrench - while tightening battery down</b>		DAYS PER WEEK	
	26. 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 stepped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY. <b>was tightening down battery, when wrench slipped and caught fan belt. this twisted wrist and broke it.</b>		27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip) <b>Dr. James Hutchinson 40917 Calan St. Hunting Downs, 91639</b>		27a. Phone Number <b>(555) 629-0174</b>	
	28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip)		28a. Phone Number		28b. Employee treated in Emergency Room? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*						
EMPLOYEE	30. EMPLOYEE NAME <b>Johnny B. Goode</b>		31. SOCIAL SECURITY NUMBER <b>503-00-0001</b>		32. DATE OF BIRTH (mm/dd/yy) <b>8/18/41</b>	
	34. HOME ADDRESS (Only box Street, City, Zip) <b>703 Sports Lane, Camelback, 91607</b>		33. PHONE NUMBER <b>(555) 614-1091</b>		36. DATE OF HIRE (mm/dd/yy) <b>8/3/01</b>	
	34. SEX: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) <b>Auto Mechanic</b>		37a. EMPLOYMENT STATUS: <input checked="" type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal	
	37. EMPLOYEE USUALLY WORKS <b>8</b> hours per day, <b>5</b> days per week, <b>40</b> total weekly hours		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED? <b>8380</b>		38. GROSS WAGES/SALARY <b>\$ 800</b> per WEEK	
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Completed By (type or print) <b>Janice Evarton</b>		Signature & Title <b>Janice Evarton secretary</b>		
Date (mm / dd / yy) <b>7/19/02</b>		Date (mm / dd / yy) <b>7/19/02</b>				
*Confidential information may be disclosed only to the employee, former employee, or their personal representative (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.						

State of California <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		Please complete in triplicate (type if possible) Mail two copies to: <b>INTERCARE INSURANCE SERVICES</b> P.O. Box 579 Roseville, CA 95661 Intercare 1 (800) 771-5454 FAX 1 (877) 382-5050		 <b>OSHA CASE NO.</b>  <b>FATALITY</b> <input type="checkbox"/>	
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.		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.			
E M P L O Y E R	1. FIRM NAME		1a. Policy Number		Please do not use this Column <b>CASE NUMBER</b> <b>OWNERSHIP</b> <b>INDUSTRY</b> <b>OCCUPATION</b> <b>SEX</b> <b>AGE</b> <b>DAILY HOURS</b> <b>DAYS PER WEEK</b> <b>WEEKLY HOURS</b> <b>WEEKLY WAGE</b> <b>COUNTY</b> <b>NATURE OF INJURY</b> <b>PART OF BODY</b> <b>SOURCE</b> <b>EVENT</b> <b>SECONDARY SOURCE</b> <b>EXTENT OF INJURY</b>
	2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number		
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct. no.		
I N J U R Y	6. TYPE OF EMPLOYER: <input type="checkbox"/> h/vals <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____		7. DATE OF INJURY / ONSET OF ILLNESS (mm / dd / yy)		SEX  AGE  DAILY HOURS  DAYS PER WEEK  WEEKLY HOURS  WEEKLY WAGE  COUNTY  NATURE OF INJURY  PART OF BODY  SOURCE  EVENT  SECONDARY SOURCE  EXTENT OF INJURY
	8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM		
	10. IF EMPLOYEE DIED, DATE OF DEATH (mm / dd / yy)		11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	12. DATE LAST WORKED (mm / dd / yy)		13. DATE RETURNED TO WORK (mm / dd / yy)		
O R S	14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		SEX  AGE  DAILY HOURS  DAYS PER WEEK  WEEKLY HOURS  WEEKLY WAGE  COUNTY  NATURE OF INJURY  PART OF BODY  SOURCE  EVENT  SECONDARY SOURCE  EXTENT OF INJURY
	16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm / dd / yy)		
	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm / dd / yy)		19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning		
	20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		
I N J U R Y	21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No		22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		SEX  AGE  DAILY HOURS  DAYS PER WEEK  WEEKLY HOURS  WEEKLY WAGE  COUNTY  NATURE OF INJURY  PART OF BODY  SOURCE  EVENT  SECONDARY SOURCE  EXTENT OF INJURY
	23. Other Workers Injured/ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.		
	25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck		26. 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.		
	27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)		27a. Phone Number		
E M P L O Y E R	28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes list NAME AND ADDRESS OF HOSPITAL in block 26)		28a. Phone Number		SEX  AGE  DAILY HOURS  DAYS PER WEEK  WEEKLY HOURS  WEEKLY WAGE  COUNTY  NATURE OF INJURY  PART OF BODY  SOURCE  EVENT  SECONDARY SOURCE  EXTENT OF INJURY
	29. Employee treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No		30. EMPLOYER NAME		
	31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/yy)		
	33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER		
O R S	34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		SEX  AGE  DAILY HOURS  DAYS PER WEEK  WEEKLY HOURS  WEEKLY WAGE  COUNTY  NATURE OF INJURY  PART OF BODY  SOURCE  EVENT  SECONDARY SOURCE  EXTENT OF INJURY
	36. DATE OF HIRE (mm/yy)		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		
	37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?		
	38. GROSS WAGES/SALARY \$ _____ per _____		38. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Completed By (type or print)		Signature & Title		Date (mm / dd / yy)	
*Confidential information may be disclosed only to the employee, former employee, or their personal representative (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.					