STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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 **self-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 this report to Division of Labor Statistics and Research, 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** — PLEASE DO NOT USE THIS COLUMN
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.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

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

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved ? ☐ Yes ☐ No

ICD-9 Code ___ ___ ___ . ___ ___

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

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify the planned course, scope, frequency and duration, including an estimated date of completion.

25. If hospitalized as inpatient, give hospital name and location. Date admitted Mo. Day Yr. Estimated stay

26. **WORK STATUS**—Is patient able to perform usual occupation? ☐ Yes ☐ No
If "no", date when patient can return to: Regular work ____/____/____
Modified work ____/____/____ Specify restrictions ____
Is permanent residual disability anticipated? ☐ Yes ☐ No
If yes, to what extent? ____

Doctor's Signature ____ Date ____ CA License Number ____
Doctor Name and Degree (please type) ____ IRS Number ____
Address ____ Telephone Number ( ) ____

FORM 5021

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.