State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

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 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
1a. Policy Number
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
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
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? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM 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
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ 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 INJURYIILLNESS, 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
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ 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
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

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

• 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.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

FRESNO COUNTY FIRE

PROTECTION DISTRICT

PHYSICAL/MENTAL STRESS JOB DESCRIPTION FOR PAID CALL FIREFIGHTER (PCF)

A description of the physical and mental stresses to which a PCF is subjected to in the District is given below. Your judgment is needed as to the employee's ability to perform the required duties. In your conclusion, take into account the long-range outlook for continued performance, and the employee's ability to safety perform these duties without significant increased risk of injury to self or others because of your medical conditions.

PCF's work as part-time employees, and may work as a PCF Company Officer or PCF Fire Engine Operator, and generally under the close supervision of a Career Firefighter. PCF's perform heavy physical work involved in firefighting, respond to medical emergencies/rescue work, and perform other public service tasks as required. The individual may be responsible for the care and operation of fire apparatus such as an engine, water tender or rescue vehicle in connection with extinguishing wildland, structural and other fires. The PCF may be responsible to drive fire apparatus under emergency and non-emergency conditions in a manner that assures safety both to the public and the fire crew being transported. Additionally, the PCF, when dispatched, may be required to drive long distances.

During the year there may be periods of several weeks during which no stressful situations occur, and then at a moment's notice, a PCF could be assigned to an emergency incident that would demand all the necessary resources to cope with the situation. On initial attack fire situations, in the absence of the Battalion Chief or Captain, the PCF may act as Incident Commander to size-up the fire or emergency, deploy personnel and equipment, and aggressively follow a plan of action to keep the fire acreage or damage minimal.

The PCF is expected to have the endurance to perform arduous physical labor or emergency situations that could last 24 hours or more. The PCF may be assigned to the night shift and required to sleep during the day to be ready for the following night shift. Day sleeping, due to the times of shift change, combined with high temperature (100+degrees), smoke, dust and noise, makes rest quite difficult to obtain. Normal regularity of meals becomes impossible in these situations.

The PCF must be able to think clearly and use good judgment. The individual should possess color vision sufficient to discriminate between electrical cable and pipe color coding; color vision to correctly identify vehicle colors; normal visual acuity or corrected to not less than 20/30 in each eye; hearing adequacy within speech frequencies; physical strength and agility; weight in proportion to height; not more than mildly susceptible to poison oak; normal use of both hands and feet.

Applicant/PCF's Name_____ SS#_____
Doctor's Name_____Signature_____
Address_____City_____Zip_____
Telephone # _____Date of Review_____

I have read the physical performance requirements for Paid-Call Firefighter and have considered this employee's medical condition(s) as they relate to his/her ability to perform the full scope of required duties.

A. Fully meets the requirements of the job/may return to full duty immediately.
B. May not return to duty at this time, but should be able to return on or about:_____ (Date)
C. Is NOT capable of performing the described duties.

NOTE: If either "B" or "C" is checked, please describe your findings using the lower portion of this form.

REMARKS or
FINDINGS:_____
_____
_____
_____

Form: FCO-10