



Office of Risk Management

CAL/OSHA REPORTING AND NOTIFICATION REQUIREMENTS: SERIOUS INJURY/ILLNESS OR FATALITY

CAL/OSHA regulations require that employers must report any Serious/Injury/Illness or Fatality to the nearest CAL/OSHA District Office. **Long Beach CAL/OSHA office (562)506-0810**

CALIFORNIA CODE OF REGULATIONS, TITLE 8 SECTION 342(a) STATES:

“Every employer shall report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious injury or illness or death, of an employee occurring in a place of employment or in connection with any employment.”

Labor Code 6302(h) “Serious injury or illness” means any injury or illness occurring in a place of employment or in connection with any employment that requires inpatient hospitalization, for other than medical observation or diagnostic testing, or in which an employee suffers an amputation, the loss of an eye, or any serious degree of permanent disfigurement, but does not include any injury or illness or death caused by an accident on a public street or highway, unless the accident occurred in a construction zone.

Labor Code 6302(i) “Serious exposure” means any exposure of an employee to a hazardous substance when the exposure occurs as a result of an incident, accident, emergency, or exposure over time and is in a degree or amount sufficient to create a realistic possibility that death or serious physical harm in the future could result from the actual hazard created by the exposure.

The **8- hour window** timeframe begins when the employer knows or “with diligent inquiry” would have known of the serious injury/illness or death. The employer means someone of management or supervisory capacity.

- Report serious incidents or deaths to CAL/OSHA no later than:
 - Eight hours after occurrence of the incident; or
 - Eight hours after occurrence of fatality, regardless of time elapsed between the incident and death
- Reportable incidents are those which result in:
 - Death of an employee
 - Hospitalization for more than 24 hours other than for observation
 - Loss or serious disfigurement of any body part
 - The in-patient hospitalization of three or more employees as a result of a work-related incident
- Reporting party shall include the following information, if available
 - Time and date of accident
 - Employer’s name, address and telephone number
 - Name and job title of person reporting the accident
 - Address of site of accident or event
 - Name of person to contact at site of accident
 - Name and address of injured employee
 - Nature of injury
 - Location to where injured employee(s) was (were) moved
 - Identify other law enforcement agencies present at the site of accident
 - Description of accident and whether the accident scene and/or physical evidence has been altered

WORKERS' COMP. INFORMATION REPORT FORM

Date and Time of accident/event/death	
Employer's name, address and telephone number	Lynwood Unified School District 1321 Bullis Road Lynwood, CA 90262 (310) 886 – 1600 ext. 8053 Director of RM (323)949-6031 After Hours
Name and job title of the person reporting the accident	
Address of accident/event site	
Name of person to contact at accident/event site	
Name, address and date of birth of injured employee(s)	
Nature of injuries	
Location where injured employee(s) was/were taken for medical treatment	
List and identity of other law enforcement agencies present at the accident/event site	
Description of accident/event and whether the accident scene or instrumentality has been altered.	

WORKERS' COMPENSATION - EMERGENCY CONTACT LIST

- **Tiffany Bell, SIA, WCCP, CPDM**
Director of Risk Management
(310) 886-1600 ext. 8053 Direct
(310) 886-1414 fax

(323) 949-6031 Cell
tbell@mylusd.org
- Intercare Holding Insurance Service
P.O. Box 7111
Pasadena, CA 91109
(818) 459-8290 Office
(916) 781-5688 FAX

CAL OSHA OFFICE

- **Long Beach District Office**
3939 Atlantic Ave, Suite 212
Long Beach, CA 90807
(562) 506-0810
(562) 426-8340 FAX
DOSHLBO@dir.ca.gov

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400
SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900).

DECEASED EMPLOYEE:

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

JOB TITLE AND NATURE OF DUTIES: _____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____

CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? ____ YES ____ NO

IF YES, TO WHOM: _____

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS," IF ONE WAS FILED.

PLEASE NOTE:

IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

() INSURED () SELF-INSURED () LEGALLY UNINSURED

EMPLOYER: _____ INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____ STREET: _____

CITY/STATE: _____ ZIP: _____ CITY/STATE: _____ ZIP: _____

TELEPHONE: _____ TELEPHONE: _____
(INCLUDE AREA CODE) (INCLUDE AREA CODE)

BY: _____

TITLE: _____

DATE: _____