Kern County Sheriff's Office

Policies And Procedures

TITLE: **EMPLOYER'S REPORT OF OCCUPATIONAL INJURY FORM** NO: N-210			
APPROVED: **Donny Youngblood, Sheriff-Coroner**			
EFFECTIVE: September 15, 1993	REVIEWED: 06/01/2007	REVISED: 03/01/2007	UPDATED: 03/07/2008

POLICY

The EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS form is used to report an occupational injury or illness to the State of California via Risk Management.

Attached is a copy of an EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS form (Form 5020 (Rev7) June 2002) (Attached Exhibit A). The following guidelines will be used to complete the form:

LINE #

1. Should read "County of Kern".

   1a. Leave this space blank.

2. Should read "1115 Truxtun Avenue, Bakersfield, CA 93301".

   2a. Should read County of Kern Workers' Compensation Services phone number (661) 868-3801.

3. List the name and address of the Sheriff's Office facility or station where the injured or ill employee is assigned.

   3a. Leave this space blank.

4. Should read "County Government."

5. Leave this space blank.

6. COUNTY box should have a "✓" in it.

7. List the date of injury or onset of illness.

8. List the time injury/illness occurred.

9. List the time the injured/ill employee started the shift in which the incident occurred.

10. If the employee died as a result of the incident, list date of death.

11. If the employee missed a full day beyond the date of the injury/illness due to the work related incident check the "Yes" box. If not, check the "No" box.

12. If the employee missed a full day beyond the date of the injury/illness, list the last

date worked. If the employee did not miss work, write "N/A".

13. If the employee missed work, list the date they returned. If they did not miss work, write "N/A".

14. Check the box if the employee is still off work. If not, leave the box blank.

15. If the employee received full pay for the last day worked or for the day of the injury or illness, check the "Yes" box. In most cases, when an employee seeks medical treatment during a shift immediately after an injury or illness, they are compensated at regular pay for the remainder of the shift. If not, check the "No"□ box.

16. If the employee is eligible for benefits under Labor Code Section 4850 (Safety Members) check the "Yes" box. For other others check the "No" box.

17. List the date the Office first learned that the injury/illness resulted in medical treatment beyond first aid or lost time beyond the date of injury or illness.

18. List the date the employee was provided the employee claim form, per Section N-230.

19. Describe the injury or illness. It is appropriate to list the description as stated by the employee or as diagnosed by a physician. List the part of the body affected.

20. List the location where the incident occurred. Be specific.

    20a. List the county in which the incident occurred.

21. If the injury/illness occurred on any Office premises, check "Yes". If not, check "No".

22. List the name of the facility or station area in which the incident occurred. (Metropolitan Patrol, Wasco Substation, Pre-Trial Facility, etc.)

23. If other employees were injured or ill in the same incident, check "Yes". If not, check "No".

24. List the equipment, materials and chemicals the employee was using when the incident occurred

25. Describe the activity the employee was performing when the incident occurred.

26. Describe how the incident occurred. Describe the sequence of events. It is appropriate in some cases to begin the description with employee claims or employee stated. Be specific; include sufficient details; attach additional page if necessary. Do not refer to another document in lieu of completing this section.

27. List the name of the physician who treated the employee as a result of this incident.

    27a. List the phone number of the physician.

28. List the name and address of the hospital if the employee was hospitalized as a result of this incident.

    28a. List the phone number of the hospital.

29. If employee was treated in the Emergency Room, check appropriate box.

30. List the name of the injured/ill employee.

31. List the Social Security Number of the injured/ill employee.

32. List the employee's date of birth.

33. List the employee's home address.

    33a. List the employee's home phone number.

34. Place an "X" in the appropriate box for male or female.

35. List the job classification of the employee. (Deputy Sheriff, Office Services Technician, Detentions Deputy, etc.)

36. List the employee's date of hire.

37. List the hours regularly worked per day, the number of days per week and the total weekly hours.

    37a. Check employment status; full time, part time, temporary (extra-help).

    37b. List the Budget Unit Code 2210.

38. List the bi-weekly or hourly wages.

39. This information is used to determine disability payments. If the employee is eligible for benefits under Labor Code Section 4850 (Safety Members: deputy sheriff, detentions deputies, etc.), the information is not needed, check the "No" box. For ALL OTHERS, check the "Yes" box if appropriate.

Type or print the name of the supervisor completing the form.

Signature and title of supervisor completing the form.

Title of supervisor completing the form.

Date form was completed.

End of form.

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