INSTRUCTIONS FOR MANUALLY COMPLETING EMPLOYER'S REPORT OF INJURY (FORM 5020 rev7)

The Employer's Report of Occupational injury or Illness (Supervisor's Report) is to be completed by the injured employee's immediate supervisor **within 24 hours.**

Once submitted, a copy must be immediately provided to your Department Safety Coordinator.

If the 5020 form is filled out manually, not using the Online Injury reporting Tool, then the form must be forwarded to Risk Management by email to workcomp@sonoma-county.org or facsimile at 707-565-3501

The following are step-by-step instructions to complete the Supervisor's Report. For the purposes of these instructions, the term "injury" also means an illness or exposure. The numbers will correspond with the boxes that must be filled out on the Employer's Report of Injury (5020 form)

EMPLOYER INFORMATION:

1. Enter employer name
2. Enter mailing address for employer
3. Enter location of employer if different than mailing address
4. Enter nature of your business

INJURY OR ILLNESS:

7. Enter the date the employee was injured.

Injury: If the injury or exposure was caused by an accident, happened as the direct result of a specific action, or began suddenly due to an event or condition, enter date (month, day, and year) the injury or exposure occurred as the "Date of Injury". If date is unknown, follow the guidance below under 'Cumulative/Ergonomic/Repetitive Motion Injury.'

Illness: If this is an illness, enter the date the condition was diagnosed as an occupational illness by a medical professional. If this is an alleged or undiagnosed illness enter the date the employee was sent to the Occupational Medicine Provider for an evaluation

Re-injury: If this is believed to be a reoccurrence of a previous injury which healed and resolved, clearly note this is believed to be a "re-injury" in box #25, and enter the date (month, day, and year) the body part was re-injured as the "Date of Injury".

Cumulative/Ergonomic/Repetitive Motion Injury: An ergonomic, repetitive motion or cumulative trauma injury is caused by repeated actions or activities over a period of time. It is usually not possible to determine the exact date an ergonomic injury began. Therefore, the method to establish the "Date of Injury" for an ergonomic injury for reporting and recordkeeping purposes is to determine which of the following occurred first:

- The date the injury was first reported, or
- The date of diagnosis by a licensed medical professional, or
- If the employee is currently off work, the first day of lost time due to this injury.

These events could all happen on the same day, but, in most circumstances, one will occur before the other(s). Confirm which of these occurred first, and enter that date as the "Date of Injury". Do not enter, "unknown", "continuous", "on-going", or dates from the past.

8. Indicate time injury occurred if known.
   If this was an ergonomic (repetitive motion injury) leave this section blank
9. Indicate time employee began work on date of injury.
10. Date of Death--Complete if appropriate.
11. Check appropriate box, indicating whether employee was able to work after the injury date.
12. Indicate date employee last worked.
13. Complete if employee has returned to work.
14. Check if Employee is still off work when you complete this form
    Check box if appropriate.
15. If Employee seeks medical treatment on day of injury, their full wages will be paid for that day.
    Check appropriate box. This is an important field to complete as we need to determine when the waiting period commences.
17. Enter first day employer had knowledge of the injury.
    Enter the month, day, and year a manager, supervisor, or administrative staff (i.e., Director, Officer, Analyst, etc.), first became aware the employee suffered or reports a work related injury that results in lost time beyond the date of injury or which requires medical treatment beyond first aid.
    <u>Example:</u> If EE trips and lets you know that they are fine, no medical treatment is needed or time off from work, there is no workplace injury at this time. If they come back a week later asking for medical treatment that is now the date of employers knowledge of the injury.

18. Enter date Claim Form (DWC 1) was provided to employee.
    Central HR will provide this form to employee, it will be sent US mail to their home address on file.
19. Indicate part of body injured and type of injury sustained.
    List all body parts injured, or affected by illness or exposure (e.g. wrist, low back, knee)
20. Enter location where employee was injured.

Provide the name of the building and location, and the zip code of the location where the injury occurred. For injuries that occurred outside of County locations, provide the address.

21. On Employer's Premises? Check appropriate box.
22. Enter department where employee was injured if appropriate.
    e.g. loading dock, jail, cell, cubicle, etc.
23. Other Workers injured or ill in this event? Check appropriate box.
24. Equipment, Materials and Chemicals the employee was using when event or exposure occurred. Complete if appropriate.
25. Specific activity the employee was performing when event or exposure occurred.
    Indicate what employee was doing when injured. Describe the injury, and/or symptoms being reported by the employee
26. How injury/illness occurred. Describe the sequence of events. Specify the object or exposure which directly produced the injury. Briefly describe how injury occurred.
    e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld and burned his right hand. (use a sperate sheet if necessary and attached to email)
27. Indicate name of physician to whom employee was sent. If known
27A. Enter doctor's phone number if known.
28. Hospitalized as an inpatient overnight? Check appropriate box.
    If yes, then enter the name of the hospital.
28A. Enter hospital's phone number if known.
29. Employee treated in emergency room? Check appropriate box.

EMPLOYEE INFORMATION:

30. Enter employee's name. Include middle initial if appropriate.
31. Enter Social Security Number for anyone without an Employe ID code—volunteers, SAC crew members
32. Enter date of birth if known
33. Enter the most current address of the employee. Please be sure to clarify with the employee their current address.
34. Employee Sex—optional, Check appropriate box.
35. Occupation (regular job title, NO initials, abbreviations or numbers) Enter their job title.
36. Enter date hired by the employer, if known
37. Employee usually Works xx hours per day, xx days per week, and XX total weekly hours.
    Fill in each line with the appropriate number.
37A. Employment Status: Check appropriate box.
37B. Employee ID #--5 digit number, e.g. number used to fill out timecard
38. Gross Wages/Salary: Leave blank, info will be provided by county payroll
39. Other Payments not Reported as Wages: Leave blank, info will be provided by county payroll

COMPLETED BY:

Type or print your name
Signature, Title & Phone Number
Date (mm/dd/yy)—Date you are completing this form