Accident Report

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF OCCUPATIONAL SAFETY AND HEALTH

☐ **Fatality**

Date of Death ____________________

MOD	Date	1. Reporting ID R D 9506	2. Previous Activity? If Yes, Enter Type: Number: ☐ Yes ☐ No	3. Event Number (Identifies this Report) ▶
4. a ☐ Change?	b. Establishment Name			5. Employer ID (State's option)
6. a ☐ Change?	b. **Site Location (Street, City, State, Zip)** **THIS SHOULD BE THE ACTUAL SITE/IF ON A CORNER PROVIDE X-SECTION OF STREETS**		7. City Code	8. County Code
9. Mailing Address (If different) (Street, City, State, Zip)			Phone Number	
Industry Ownership	10. Type of Business		11. Primary SIC	12. No of Employees
	13. Ownership (Mark "x" in one box) a. ☐ Private Sector b. ☐ Local Government c. ☐ State Government		d. ☐ Federal Government	
Receipt Information	14. Reported By		15. Date	16. Time ☐ AM ☐ PM
	17. Job Title		18 Telephone Number	
Employer Representative	19. Group Name(s)			
Site Contact	20. **Name and Location**			
	21**. Job Title** THIS SHOULD ONLY BE THE PERSON **AUTHORIZED** TO ENGAGE WITH THE COMPLIANCE PERSON		22. Telephone Number	

Classification	23. (Mark "X" In one box)	a. ☐ Fatality	b. ☐ Catastrophe	c. ☐ Non-Fatality/Catastrophe Reported by Professional or Media	d. ☐ Non-Fatality/Catastrophe Reported by Employer or Other Party

Event Description	24. **Event Date**	25. **Event Time** ☐ AM ☐ PM	26. Number of Fatalities	27. Number of Hospitalized Injuries	28. Number of Non-hospitalized Injuries	29. Number Unaccounted for

30. Type of Event (e.g. Fall from scaffold)

Name/Address of Injured	Age	Occupation	Injury

Duty Officer/Clerk Name:

Accident Description (Specify Mechanism/Condition/Hazardous Substance):

Describe all extenuating/mitigating circumstances such as empl has documented pre-existing medical issues including heart problems/ employee has to self medicate/ employee had drugs/alcohol etc. Also describe if employee was on break/ performing personal grooming/ on cell phone etc. Where you do not get a medical determination AS TO TREATMENT. Let intake officer know you don't know yet, but will get back with the findings. **THE IDEA IS TO STOP THE CLOCK.**

Location Where Injured Employee was Moved to:

Other Law Enforcement Agencies Present at Site:

Workers' Compensation Insurance Carrier (Name & Address): (For Fatalities Only)

Action	32. Inspection Planned? ☐ Yes ☐ No	If No Reason:	33. Supervisor(s) Assigned a. b.	34. CSE/IH Assigned a. b.

35. Optional Information

Type	ID	Value	Type	ID	Value

Comments:

36. Total Entries

37. District Manager:

Signature Date: Telephone Number (   )

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