☐ **CORONA** 2071 Compton Avenue, Suite 102 Corona, CA 92881 **(951) 549-0900 Fax (951) 278-8552**
☐ **CHINO** 12488 Central Avenue, Suite B Chino, CA 91710 **(909) 613-0100 Fax (909) 613-0600**

Doctors' First Report of Occupational Illness or Injury

Within 5 days of your initial examination, for every occupational injury or illness, send this report to Insurer or employer (only if self-insured). Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco, CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days. For a supply of this form, please call (415) 557-1924.

1. Insurer Name/Address:	**2. Employer Name**: **3. Address**: **4. Nature of Business**:	**PLEASE DO NOT USE THIS COLUMN** Case No.
5. Patient Name: **8. Address**: **10. Occupation**: (Specific Job Title)	**6. SEX**: **7. DOB**: **9. Telephone #**: **11. Social Security Number**:	Industry County Age
12. Injured at: City:	County:	Hazard
13. Date and hour of Injury or onset of illness:	**14. Date last worked**:	Disease
15. Date and hour of first injury, examination or treatment:	**16. Have you (or your office) previously treated patient** ☐Yes ☐ No	Hospitalization
17. Patient, please describe how the accident or exposure happened (Be Specific) PATIENT STATED: "		Occupation Return Date Code

18. Subjective Complaints:

Objective Findings:

20. Diagnosis: Chemical or toxic compounds involved ☐ Yes ☐ No **X-RAY** ☐ Yes ☐ No

21. Findings consistent with patient's statement ☐ Yes ☐ No	**22. Other condition that will impede recovery** ☐ Yes ☐ No	**Explain**:

23. Treatment Rendered/Planned: PATIENT WAS EVALUATED AND TREATED
If further treatment required, specify treatment:
Estimated Duration:
24. If hospitalized as inpatient, give hospital name/location:
Admit Date: **Estimated Stay**:

25. Work Status: Is patient able to perform usual work? ☐ Yes ☐ No

If no, patient can return to: Regular Work: Modified Work: Restrictions:

Naser W. Azar, M.D
2071 Compton Avenue, Suite #102
Corona, CA 92881
CA License: A54778
IRS Number: 33-0697381
Phone #: (951) 549-0900
DOCTOR'S SIGNATURE: ______________________________ **DATE:** _____/______/_________
I have not violated LC 139.3 and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Any person who makes or causes to be made any knowingly false or fraudulent material statement of material Representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

WC