West San Gabriel Workers' Compensation Joint Powers Authority

DEATH OR SERIOUS INJURY/ILLNESS REPORT KIT

These materials are to be used to report the incident to CAL OSHA

WORKERS' COMPENSATION DEATH OR SERIOUS INJURY/ILLNESS REPORT KIT

INCIDENTS MUST BE REPORTED IMMEDIATELY TO CAL OSHA
(no longer than eight (8) hours after the employer's knowledge)

This kit includes the following:

- **Emergency Contact List**
- **List of OSHA District Offices**
- **Information Report Form**
- **DIA Form 510 Notice of Employee Death**

1. IN CASE OF THE DEATH OF AN EMPLOYEE

- ✓ Complete Workers' Compensation Injury Report Kit
- ✓ Complete the information report form enclosed. If there is information missing, do not delay the report. Missing information can be called in later.
- ✓ Record the report number provided by the agent as proof the report was made.
- ✓ If the deceased **does not** have any surviving minor children complete DIA Form 510 Notice of Employee Death. The form can be located at https://www.dir.ca.gov/dwc/diaform510.pdf
- ✓ Forward the original to:

  Administrative Director
  State of California Department of Industrial Relations Division
  of Workers' Compensation
  P.O. Box 422400
  San Francisco, CA 94142.

✓This form must be filed within 60 days of employer knowledge. Keep a copy for your records and forward a copy to York Risk Services Group, Inc. at (909) 608-7171.

✓Notify Tiffany Bell, LMP Risk Services, Inc. (310)308-3313

Immediately report by telephone or facsimile to the nearest OSHA District Office. The notified office will route the information to the correct office.

2. IN CASE OF A SERIOUS INJURY OR ILLNESS

Requiring inpatient hospitalization for a period in excess of twenty-four (24) hours for other than medical observation, or in which an employee suffers the loss of any member of the body, or suffers a serious degree of physical disfigurement.

- ✓ Immediately report by telephone or facsimile to the nearest OSHA District Office. The notified office will route the information to the correct office.
- ✓ Complete the information report form enclosed. If there is information missing, do not delay the report. Missing information can be called in later.
- ✓ Record the report number provided by the agent as proof the report was made.
- ✓ Notify York Risk Services Group, Inc. at (909) 608-7171
- ✓ Notify Tiffany Bell, LMP Risk Services, Inc. at (310) 308-3313

Emergency Contact List

<table>
<tr><td>York Services Group, Inc.
8855 Haven Ave.
Rancho Cucamonga, CA 91730
(909) 608-7171
Stephanie Millhollon (909) 942-4893
Linda White (909) 942-4888</td><td colspan="2">District Contacts</td></tr>
<tr><td>LMP Risk Services, Inc.
11432 South St. #160
Cerritos, CA 90703
Tiffany Bell
(310) 308-3313</td><td>Arcadia

Dierk Essein
dessein@ausd.net

Jaime Morales
jmorales@ausd.net</td><td>Burbank

David Jaynes
DavidJaynes@burbankusd.org</td></tr>
<tr><td>Bureau Veritas North America, Inc.
1665 Scenic Avenue Suite 200
Costa Mesa, CA 92626
John Olson
(714) 431-4156
(714) 932-2378</td><td>Duarte

Jim Bauler
jbauler@duarteusd.org</td><td>San Gabriel

Joyce Yeh
yeh_j@sgusd.k12.ca.us</td></tr>
<tr><td>Alliant Insurance Services
1301 E. Dove Street
Newport Beach, CA 92660

Lilian Vanvieldt (310) 383-4453

Angela Hatley (909) 938-3038</td><td>San Marino

Linda De La Torre
hrtorre@smusd.us</td><td>Temple City

Marianne Sarrail
Msarrail@tcusd.net</td></tr>
<tr><td>West San Gabriel WCJPA
(626) 548-5005</td><td>West Covina

Drew Passalacqua
dpassalacqua@wcusd.org

Ray Wilds
rwilds@wcusd.org</td><td>Valle Lindo

Albert Crespo
crespoa@aol.com</td></tr>
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CALIFORNIA OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (CAL OSHA) DISTRICT OFFICES

Los Angeles
320 West 4th Street Ste. 850
Los Angeles, CA 90013
(213) 576-7451
Fax (213) 576-7461

Monrovia
750 Royal Oaks Drive Ste. 104
Monrovia, CA 91016
(626) 256-7913
Fax (626) 359-4291

Van Nuys
6150 Van Nuys Blvd. Ste. 405
Van Nuys, CA 91401
(818) 901-5403
Fax (818) 901-5578

West Covina
1906 West Garvey Ave. So, Ste. 200
West Covina, CA 91790
(626)472-0046
Fax (626) 472-7708

Information Report Form

The agent at the District OSHA Office will need the following information:

Time of the Accident or Incident		
Date of the Accident or Incident		
Employer's Name		
Employer's Address		
Employer's Telephone Number		
Name and Title of Person Reporting		
Address of the Site where the accident or indent took place.		
Name of Contact Person at the Site		
Name(s) of the Injured person		
Address of injured person (s)		
Date of Birth		
Nature of Injuries		
Where taken for Medical Treatment		
Identity of other Law Enforcement Person Present at Site		
Other Law Enforcement Person Present at Site.		
Description of accident event and whether the scene or objects have been moved or altered.		
	Report Number (from OSHA)	

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: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

BY: _____

TITLE: _____

DATE: _____

DIA 510 (REV. 9/84)