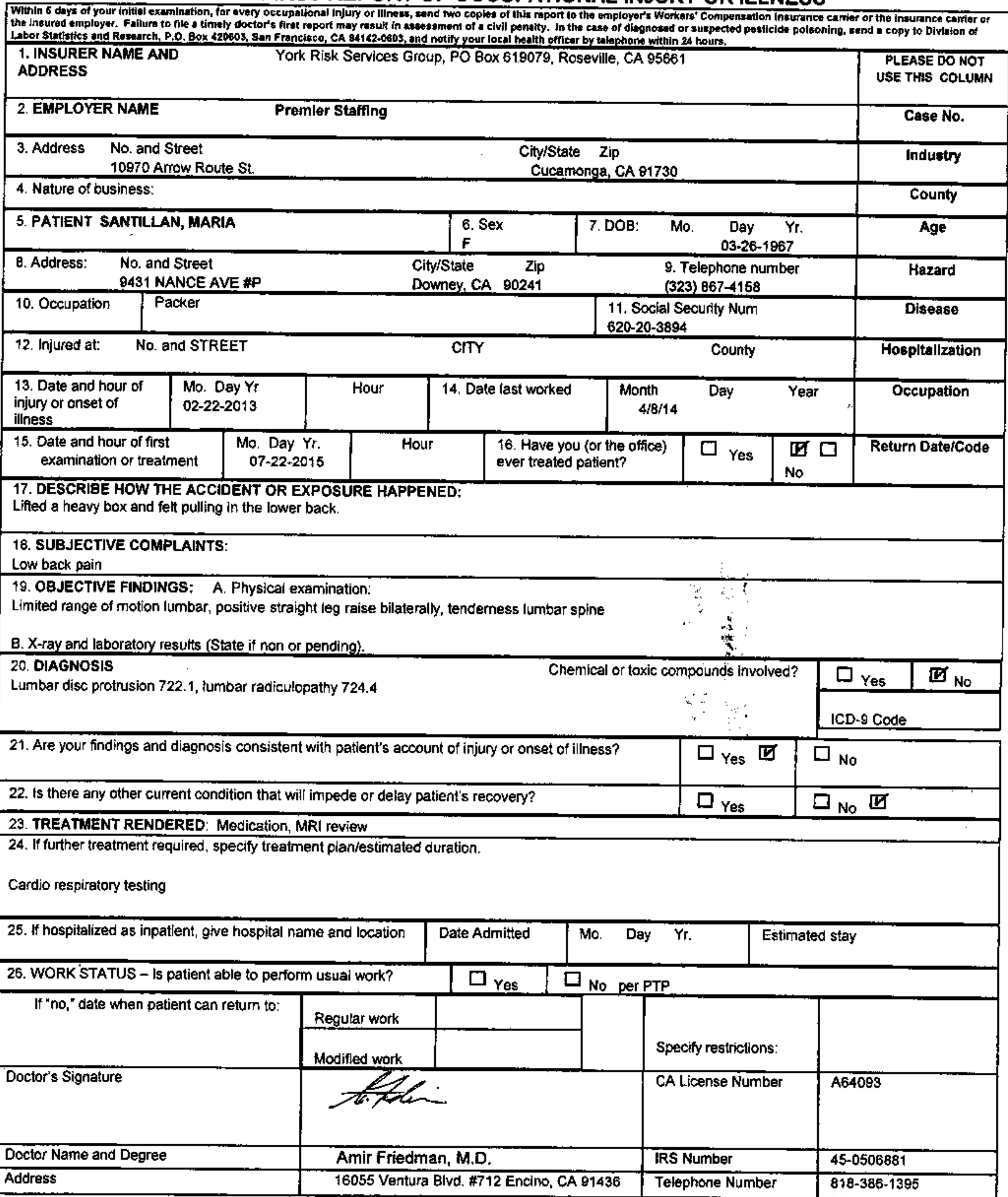
STATE OF CALIFORNIA

# DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS



**Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's Workers' Compensation insurance carrier or the insurance carrier or the insured employer. Failure to file a timely doctor's first report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.**

| Item | Entry | PLEASE DO NOT USE THIS COLUMN |
|---|---|---|
| **1. INSURER NAME AND ADDRESS** | York Risk Services Group, PO Box 619079, Roseville, CA 95661 | |
| **2. EMPLOYER NAME** | **Premier Staffing** | **Case No.** |
| 3. Address No. and Street / City/State Zip | 10970 Arrow Route St. / Cucamonga, CA 91730 | **Industry** |
| 4. Nature of business: | | **County** |
| **5. PATIENT** | **SANTILLAN, MARIA** — 6. Sex: F — 7. DOB: Mo. Day Yr. 03-26-1967 | **Age** |
| 8. Address: No. and Street / City/State Zip | 9431 NANCE AVE #P / Downey, CA 90241 — 9. Telephone number (323) 867-4158 | **Hazard** |
| 10. Occupation | Packer — 11. Social Security Num 620-20-3894 | **Disease** |
| 12. Injured at: No. and STREET / CITY / County | | **Hospitalization** |
| 13. Date and hour of injury or onset of illness | Mo. Day Yr 02-22-2013 — Hour: — 14. Date last worked: Month Day Year 4/8/14 | **Occupation** |
| 15. Date and hour of first examination or treatment | Mo. Day Yr. 07-22-2015 — Hour: — 16. Have you (or the office) ever treated patient? ☐ Yes ☑ No | **Return Date/Code** |

**17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED:**
Lifted a heavy box and felt pulling in the lower back.

**18. SUBJECTIVE COMPLAINTS:**
Low back pain

**19. OBJECTIVE FINDINGS:** A. Physical examination:
Limited range of motion lumbar, positive straight leg raise bilaterally, tenderness lumbar spine

B. X-ray and laboratory results (State if non or pending).

**20. DIAGNOSIS**
Lumbar disc protrusion 722.1, lumbar radiculopathy 724.4

Chemical or toxic compounds involved? ☐ Yes ☑ No

ICD-9 Code

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☑ Yes ☐ No

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☑ No

23. **TREATMENT RENDERED**: Medication, MRI review

24. If further treatment required, specify treatment plan/estimated duration.

Cardio respiratory testing

| 25. If hospitalized as inpatient, give hospital name and location | Date Admitted | Mo. Day Yr. | Estimated stay |
|---|---|---|---|
| | | | |

26. WORK STATUS – Is patient able to perform usual work? ☐ Yes ☐ No per PTP

| If "no," date when patient can return to: | | | |
|---|---|---|---|
| | Regular work | | Specify restrictions: |
| | Modified work | | |
| Doctor's Signature | [signature] | CA License Number | A64093 |
| Doctor Name and Degree | Amir Friedman, M.D. | IRS Number | 45-0506881 |
| Address | 16055 Ventura Blvd. #712 Encino, CA 91436 | Telephone Number | 818-386-1395 |

**FORM 5021 (Rev. 4)** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.