SB 1159 COVID-19 REPORTING FORM

IMPORTANT NOTICE: When you, the employer, know or reasonably should know that an employee has tested positive for COVID-19, you are required to notify your workers' compensation carrier's claims administrator via fax or email.

- Positive COVID-19 tests occurring **between** July 6, 2020 through September 16, 2020 **must be reported no later than** October 30, 2020.
- Positive COVID-19 tests occurring **after** September 16, 2020 must be reported **within 3 days** of your first knowledge or of the positive test.

Filing this form **DOES NOT** report a Workers' Compensation claim. Return this completed form to your workers' compensation carrier's claims administrator as soon as possible.

Complete a separate form for each employee who has tested positive for COVID-19.

1. Please provide your company name:____
   Company address: ________________________________ Work Comp policy number: _____________________

2. Please identify the testing date for the employee who tested positive: ________________________ (MM/DD/YYYY)
   (Note: The testing date is the date that a specimen was collected from the employee for testing.)
   PCR/Viral Test? (Choose one) ☐ Yes ☐ No ☐ I don't know

3. Please provide the information below for each specific place of employment where the employee worked (meaning the actual address of the building, store, facility, or agricultural field where the employee performed work at employer's direction) in the 14-day period prior to the testing date. This may be a different location than the business address requested in number 1 above.

Location #1		**Location #2**	
Address:		Address:	
Total Employee Count for this specific location only:		Total Employee Count for this specific location only:	
Identify the last day the employee worked at this location:		Identify the last day the employee worked at this location:	
What is the highest number of employees who reported to work at this specific location in the 45-day period preceding the last day the employee worked at this location?		What is the highest number of employees who reported to work at this specific location in the 45-day period preceding the last day the employee worked at this location?	
Has this location ever been ordered to close due to a risk of infection with COVID-19?		Has this location ever been ordered to close due to a risk of infection with COVID-19?	
If YES, please explain:		If YES, please explain:	

4. Has the employee filed a WC claim or alleged the illness is work-related? (Choose one) ☐ Yes ☐ No
   If yes, be sure to report the illness as a Work Comp claim to your Work Comp Claims Administrator.

I hereby certify that I am an authorized representative of the insured named above and the information provided in this form is accurate and complete to the best of my knowledge.

______________________________ PRINT FULL NAME/TITLE

______________________________ Email address

______________________________ Date

______________________________ Phone number

______________________________ SIGNATURE