Appendix F

Sample Clandestine Laboratory Exposure Report (CLER) Instrument California Department of Justice Division of Law Enforcement Bureau of Narcotic Enforcement

CLANDESTINE LABORATORY EXPOSURE REPORT

BNE, BFS, and Task Force personnel who have received or intend to receive medical evaluations shall complete and submit this document as per CLMIP (Clandestine Laboratory Manual of Instruction and Procedure) within 24 hours to: the Clandestine Laboratory Coordinator, BNE HQ (Law Enforcement Personnel), or the Hazard Response & Evaluation Manager, BFS HQ (Scientific Support Personnel).

EMPLOYEE INFORMATION	NAME (Last, First, Middle Initial)		DATE OF BIRTH
	FIELD OFFICE OR CRIMINALISTICS LABORATORY		TITLE (SA, SAS , CRIM, etc.)
INCIDENT DATA	DATE OF LABORATORY RAID		CASE NO./OTHER AGENCY NO.
	TYPE OF DRUG LABORATORY (Methamphetamine, LSD, PCP, Cocaine conversion, etc.)		
LAB SITE	RESULTS OF DRAEGER TUBES (If available)		RESULTS OF GASTECH 1314 ____% oxygen ____% combustible gas
	PERSONAL PROTECTIVE EQUIPMENT USED FOR EACH ACTIVITY LISTED (Nomex suit, gloves, boots, etc.) A. Entry		B. Pre-assessment
	C. Assessment		D. Processing
	E. Disposal		F. Other
MEDICAL TREATMENT	PROVIDER	MEDICAL CONDITION	TYPE OF TREATMENT
	DATE FIRST AID TREATMENT RECEIVED		NAME OF DOCTOR AND PHONE NO.

NOTE: Refer to Clandestine Lab Manual for SCIF 3301 Form Submission

INFORMATION PRACTICES ACT OF 1977

AUTHORITY:	Civil Code-Section 1798, et. seq.
PURPOSE:	To provide safety and health support for IEB employees exposed to hazardous chemicals.
ROUTINE USES:	Records are maintained for internal IEB use. The only disclosure of information outside the agency would be when authorized by the subject.
EFFECT:	Failure to provide information will result in inadequate health and safety recommendations.

Employee's Signature Date Supervisor's Typed Name and Signature Date

BNE 015 (Rev. 10/91) Continue on Reverse

Source: California Department of Justice, Division of Law Enforcement, ***Clandestine Laboratory.***

CHEMICAL EXPOSURE

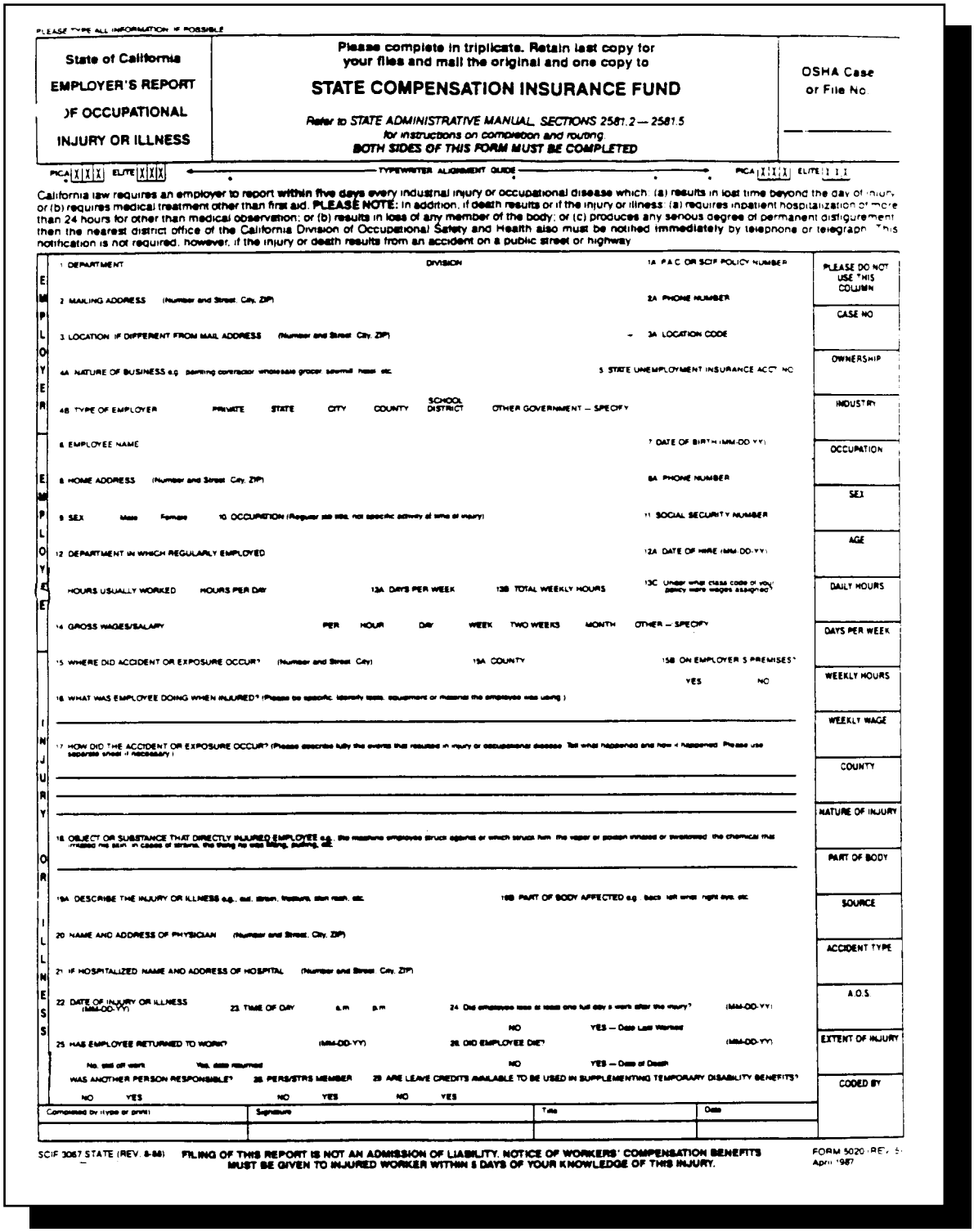
Name ALL chemicals to which you were exposed

LABORATORY RAID ACTIVITIES (Check all that apply)

ACTIVITY	Duration of Activity in Clandestine Laboratory					Symptoms as a result of laboratory activities												Special conditions in laboratory			
	Less than 1 hr.	1 hr.	1 - 4 hours	4 - 8 hours	8 + hrs. (specify)	Eyes Burn	Nose irritation	Nose Bleed	Cough	Sore Throat	Breathing Difficulty	Nausea/Queasiness	Headache	Light-Headed/Dizzy	Skin Irritation/Rash	Chemical burns	Collapse	Fire	Explosion	Uncontrolled Reactions	Leaks/Spills
A. Entry																					
B. Pre-assessment																					
C. Assessment																					
D. Processing																					
E. Disposal																					
F. Other																					

Other Symptoms (describe)

Other Conditions of Unusual Circumstances (describe)



PLEASE TYPE ALL INFORMATION IF POSSIBLE

State of California
EMPLOYER'S REPORT
OF OCCUPATIONAL
INJURY OR ILLNESS

Please complete in triplicate. Retain last copy for your files and mail the original and one copy to

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 — 2581.5 for instructions on completion and routing
BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case or File No. _____

PICA [X][X][X] ELITE [X][X][X] ← TYPEWRITER ALIGNMENT GUIDE → PICA [X][X][X] ELITE [X][X][X]

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified immediately by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1 DEPARTMENT — DIVISION — 1A P.A.C. OR SCIF POLICY NUMBER

2 MAILING ADDRESS (Number and Street, City, ZIP) — 2A PHONE NUMBER

3 LOCATION IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP) — 3A LOCATION CODE

4A NATURE OF BUSINESS e.g. painting contractor, wholesale grocer, sawmill, hotel, etc. — 5 STATE UNEMPLOYMENT INSURANCE ACCT. NO.

4B TYPE OF EMPLOYER — PRIVATE — STATE — CITY — COUNTY — SCHOOL DISTRICT — OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6 EMPLOYEE NAME — 7 DATE OF BIRTH (MM-DD-YY)

8 HOME ADDRESS (Number and Street, City, ZIP) — 8A PHONE NUMBER

9 SEX — Male — Female — 10 OCCUPATION (Regular job title, not specific activity at time of injury) — 11 SOCIAL SECURITY NUMBER

12 DEPARTMENT IN WHICH REGULARLY EMPLOYED — 12A DATE OF HIRE (MM-DD-YY)

HOURS USUALLY WORKED — HOURS PER DAY — 13A DAYS PER WEEK — 13B TOTAL WEEKLY HOURS — 13C Under what class code or (your) policy were wages assigned?

14 GROSS WAGES/SALARY — PER — HOUR — DAY — WEEK — TWO WEEKS — MONTH — OTHER — SPECIFY

INJURY OR ILLNESS

15 WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City) — 15A COUNTY — 15B ON EMPLOYER'S PREMISES? YES NO

16 WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or materials the employee was using.)

17 HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

18 OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g. the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin. In cases of strains, the thing he was lifting, pushing, etc.

19A DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc. — 19B PART OF BODY AFFECTED e.g. back, left wrist, right eye, etc.

20 NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)

21 IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)

22 DATE OF INJURY OR ILLNESS (MM-DD-YY) — 23 TIME OF DAY — a.m. — p.m. — 24 Did employee lose at least one full day's work after the injury? (MM-DD-YY) — NO — YES — Date Last Worked

25 HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY) — No, still off work — Yes, date returned — 26 DID EMPLOYEE DIE? (MM-DD-YY) — NO — YES — Date of Death

WAS ANOTHER PERSON RESPONSIBLE? NO YES — 28 PERS/STRS MEMBER NO YES — 29 ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING TEMPORARY DISABILITY BENEFITS? NO YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 STATE (REV. 8-86) **FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.** FORM 5020 (REV. 5) April 1987

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work. ☐	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment ☐	The facts do not indicate this claim of injury was work connected ☐

GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? ☐ YES ☐ NO If no, explain

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: ☐ YES ☐ NO

B. MODIFIED WORK DECISION: ☐ Condition precludes M.W. ☐ Appropriate M.W. not available ☐ M.W. arranged _____ days

Signature	Classification	Date

MANAGER'S REVIEW

DO YOU CONCUR WITH 1ST LINE SUPERVISOR'S REVIEW? ☐ YES ☐ NO If no, explain

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. BOX 9729
BAKERSFIELD, CA 93389-9729

P.O. BOX 4973
EUREKA, CA 95502-4973

P.O. BOX 40000
FRESNO, CA 93755-4000

P.O. BOX 2037
MONTEREY PARK, CA 91754-8937

P.O. BOX 12971
OAKLAND, CA 94604-2971

P.O. BOX 496049
REDDING CA, 96049-6049

P.O. BOX 254700
SACRAMENTO, CA 95865-4700

P.O. BOX 1316
SAN BERNARDINO, CA 92402-1316

P.O. BOX 85488
SAN DIEGO, CA 92138-5488

P.O. BOX 807
SAN FRANCISCO, CA 94101-0807

P.O. BOX 759
SAN JOSE, CA 95106-0759

P.O. BOX 2407
SANTA ROSA, CA 95405-0407

P.O. BOX 8000
STOCKTON, CA 95208-0016

P.O. BOX 25280
VENTURA, CA 93002-5280

Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at **1-800-736-7401** if you need help in filling out this form or obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

EMPLOYEE:

1. Name _____ Today's Date _____
2. Home Address _____
3. City _____ State _____ Zip _____
4. Date of Injury _____ Time of Injury _____ a.m. _____ p.m.
5. Address/Place where injury happened _____
6. Describe injury and part of body affected _____
7. Signature of employee _____

EMPLOYER: COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT

8. Name and address of employer _____
9. Policy # _____ 10. Employee's Soc. Sec. # ___/___/___
11. Date employer first knew of injury _____
12. Was employee paid full wages for date of injury ☐ Yes ☐ No
13. Date claim form was provided to employee _____ 14. Date employer received claim form _____
15. Name and address of insurance carrier or adjusting agency STATE COMPENSATION INSURANCE FUND
16. Signature of Employer Representative _____ Date _____
17. Title _____ 18. Telephone _____

EMPLOYER: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim **within one working day** of receipt of completed form from employee. Please return original along with your Employer's First Report of Injury to your local State Fund office.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

DWC Form 1 (1-1-90)
SCIF 3301 (Rev 6-90)

STATE COMPENSATION INSURANCE FUND

STATE FUND COPY