State of California
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF OCCUPATIONAL SAFETY AND HEALTH

Fatality________________

* W.C. Carrier _________

NARRATIVE SUMMARY

Establishment Name	Inspection Number
Management Contacted	Title

Information on Injured

Covered by Workers' Compensation Yes_____ No______

Name, Address and Phone Number	Occupation

Use additional forms(s) as needed.

Witness Name(s) and Title

*Check box preceding name if confidentiality is given.

*	Names and Title(s)	Address	Phone No.	Signed Statement?			
				Yes		No	
				Yes		No	
				Yes		No	

Summary

Use additional sheet(s) as needed.

		Signature	Date
Prepared by:	CSHO		
Reviewed by:	DM		
	Regional Manager		

Cal/OSHA 170A (03/13/14)