

**SB 1159 Reporting Form**

Please download and complete one report for each positive COVID-19 test **regardless of if alleged to be work related**. Submit by email to [claimsintake@churchmutual.com or](mailto:claimsintake@churchmutual.comor) by fax to (715) 539-4651.

This report does not generate a claim, nor does a claim qualify as a report. To submit a claim, please email or fax this form along with a completed Employee Claim Form (DWC-1) and/or Employers' First Report of Injury to [claimsintake@churchmutual.com](mailto:claimsintake@churchmutual.com) or (715) 539-4651.

If you have already submitted a completed Employee Claim Form (DWC-1) and/or Employers' First Report of Injury for a positive test and need **only** to submit this form, please complete the below, including claim number, and email [claimssupportcompliance@churchmutual.com](mailto:claimssupportcompliance@churchmutual.com) or fax to (715) 539-4651.

**Overview**

If you are aware of an employee testing positive for COVID-19 on or after July 6, 2020, you must report it to your claims administrator (California Labor Code Section 3212.88).

* Positive COVID-19 test results between July 6, 2020, and September 16, 2020, must be reported to your claims administrator by October 29, 2020.
* Positive COVID-19 test results on or after September 17, 2020, must be reported to your claims administrator within 3 business days of knowledge (or when it should reasonably have been known).

**Policy Information**

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| Policy Name (as written on policy: | | | |  | | | | | |
|  | | | | | | | | | |
| Policy #: |  | | | | Number of Employees: | | | |  |
|  |  | | | |  | | | |  |
| Primary Contact: | | |  | | | | | | |
|  | | |  | | | | | | |
| Contact Phone: | |  | | | | Contact Email: | |  | |
|  | |  | | | |  | |  | |
| Fax #: |  | | | | | Date: |  | | |

**COVID-19 Test Result Information**

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| **Employee ID Number:**  This is your internal ID number. Do not include any Personal Identifiable Information (such as SSN, DOB, etc.) in this report. |  | |
|  |  | |
| **Date of Positive COVID-19 Test:**  This is the sample collection date. Test must be a Polymerase Chain Reaction (PCR) or other viral testing approved by the FDA. Serologic (antibody) testing is not a viable test. |  | |
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| **Date Employer Notified of Positive COVID-19 Test Result:** |  | |
|  |  | |
| **Date Employee Last Worked Before Positive COVID-19 Test Result:** |  | |
|  |  | |
| **Has a Workers' Compensation Claim Been Filed for the Employee?**  No  Yes Claim #: | |  |

**Employee Location Record**

List **all** locations where employee worked at your direction during the 14-day period prior to the positive test result

*(include building, store, or facility where the employee worked).*

**Location:** Street address including suite and/or building number, city, state, and zip code of work location.

**Highest #:** Highest daily number of employees at each location.

* If the positive test occurred on or after September 17, 2020, enter highest daily number of employees in the 45 days prior to last day the employee worked.
* If the positive test occurred between July 6, 2020, and September 16, 2020, enter highest daily number of employees during that time span.

**Ordered Closure**: If a location was ordered to close by a local public health department, the State Department of Public Health, the Division of Occupational Safety and Health, or a school superintendent due to risk of infection with COVID-19, who ordered the closure, and when.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Location** | **Highest #** | **Ordered Closure** | **Date of Order** | **Ordered By** |
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| --- | --- | --- | --- |
| Name (Print): |  | Date: |  |

**Submit your report per the directions at the top of the page.**