**MANDATORY EMPLOYER REPORTING OF A POSITIVE COVID-19 TEST**

Please complete one report for each employee’s positive COVID-19 test.

The report can be emailed to reportaclaim@employers.com or faxed to 877-329-2954.

If you have any questions, please contact us at 888-682-6671.

**OVERVIEW OF CALIFORNIA LABOR CODE SECTION 3212.88**

When an employer who has five or more employees is aware that an employee has tested positive for COVID-19 on or after July 6, 2020 through January 1, 2024, the employer shall report to their claims administrator in writing via electronic mail or facsimile all of the following:

1. An employee has tested positive. For purposes of this reporting, the employer shall not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to Labor Code Section 5401.
2. The date that the employee tests positive, which is the date the specimen was collected for testing.
3. The specific address or addresses of the employee’s specific place of employment during the 14-day period preceding the date of the employee’s positive test.
4. For positive tests on or after July 6, 2020 through September 16, 2020, provide the highest number of employees who reported to work at each of the employee’s specific places of employment on any given work day between July 6, 2020 and September 17, 2020.
5. For positive tests on or after September 17, 2020, provide the highest number of employees who reported to work at the employee’s specific place of employment in the 45-day period preceding the last day the employee worked at each specific place of employment.

For all positive test results between July 6, 2020 and September 16, 2020, they must be reported by October 29, 2020.

For all positive test results on or after September 17, 2020, they must be reported within three business days.

If a specific place of employment is 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 a risk of infection with COVID-19, this information must be reported to us.

**POLICY INFORMATION:**

Policy Name, as written: Policy Name Policy Number: Policy Number

Primary Contact : Primary Contact Contact Email: Contact Email

Contact Phone #: Contact Phone # Contact Fax #: Contact Fax #

Number of Employees: Number of Employees Date: Date

**POSITIVE COVID-19 TEST INFORMATION**

Employee Identification Number: Employee Identification Number

* Do not include any personal identifiable information, i.e. name, SSN, DOB, address, etc.

Employee’s last date worked, prior to the positive test: Employee's Last Date Worked

Positive COVID-19 test date: Positive Test Date

* Date the specimen was collected for testing. The test must be a PCR (Polymerase Chain Reaction) test or a viral culture test. Both must be approved for use or approved for emergency use by the U.S. Food and Drug Administration to detect the presence of viral RNA. In addition, the viral culture test has to have the same or higher sensitivity and specificity as the PCR Test.

Date Employer was informed of the positive COVID-19 test result: Employer's Date of Notification

Specific address or addresses of the employee’s specific place of employment during the 14-day period preceding the date of the employee’s positive test: Address

 Address

For positive test results between July 6, 2020 and September 16, 2020, provide the highest number of employees who reported to work at each of the employee’s specific places of employment on any given work day between July 6, 2020 and September 17, 2020. Number of Employees

For positive test results on or after September 17, 2020, provide the highest number of employees who reported to work at the employee’s specific place of employment in the 45-day period preceding the last day the employee worked at each specific place of employment. Number of Employees

Is the employee asserting the infection is work related or has filed a workers’ compensation claim? Yes or No

Signature: Signature

Print Name: Name

Date: Date