{LETTERHEAD}

MODEL NOTICE TO LOCAL HEALTH AUTHORITY OF COVID-19 OUTBREAK

*When an employer receives notice that their workplace is identified as the location of a COVID-19 outbreak by a local health department or three or more epidemiologically linked cases in a single workplace occur within a 14-day period, CalOSHA regulations require that an employer send the following notice to their local health department within 48 hours.*

To: {DIRECTOR, LOCAL HEALTH DEPARTMENT}

From: {HR MANAGER OR OTHER RESPONSIBLE OFFICIAL}

Date: (DATE}

**Re: Notification of Covid-19 Outbreak {(INITIAL / SUPPLEMENTAL (select one))}**

We are providing this notice pursuant to CalOSHA regulations (Title 8, Subchapter 7 Section 3205.1.) to notify you of the determination of a COVID-19 outbreak or the occurrence of three or more cases of COVID-19 that are believed to be epidemiologically-linked to the workplace.

The total number of known cases detected is: {INSERT NUMBER OF CASES}

The individuals affected are as follows:

**Case 1:**

Name: {NAME}

Occupation: {OCCUPATION}

Home Address: {HOME ADDRESS}

Telephone Number: {TELEPHONE NUMBER}

Employer: {WORKPLACE LOCATION}

Work Address: {ADDRESS OF WORKPLACE}

NAICS Number of Workplace{NAICS WORKPLACE CLASSIFICATION CODE}

Date of Illness: {ADD DATE}

Location Illness Occurred: {LOCATION OF ILLNESS or unknown}

Decription of Illness: Known COVID-19 infection

Status of Illness: {INDICATE STATUS OF ILLNESS: ISOLATED/HOSPITALIZED/DECEASED (if known)}

Days Away from Work: {LIST NUMBER OF DAYS, if known}

Case 2:

Name: {NAME}

Occupation: {OCCUPATION}

Home Address: {HOME ADDRESS}

Telephone Number: {TELEPHONE NUMBER}

Employer: {WORKPLACE LOCATION}

Work Address: {ADDRESS OF WORKPLACE}

NAICS Number of Workplace{NAICS WORKPLACE CLASSIFICATION CODE}

Date of Illness: {ADD DATE}

Location Illness Occurred: {LOCATION OF ILLNESS or unknown}

Decription of Illness: Known COVID-19 infection

Status of Illness: {INDICATE STATUS OF ILLNESS: ISOLATED/HOSPITALIZED/DECEASED (if known)}

Days Away from Work: {LIST NUMBER OF DAYS, if known}

Case 3:

Name: {NAME}

Occupation: {OCCUPATION}

Home Address: {HOME ADDRESS}

Telephone Number: {TELEPHONE NUMBER}

Employer: {WORKPLACE LOCATION}

Work Address: {ADDRESS OF WORKPLACE}

NAICS Number of Workplace{NAICS WORKPLACE CLASSIFICATION CODE}

Date of Illness: {ADD DATE}

Location Illness Occurred: {LOCATION OF ILLNESS or unknown}

Decription of Illness: Known COVID-19 infection

Status of Illness: {INDICATE STATUS OF ILLNESS: ISOLATED/HOSPITALIZED/DECEASED (if known)}

Days Away from Work: {LIST NUMBER OF DAYS, if known}

{**ADD MORE AS NEEDED**}

Included in the information provided for each affected individual is the information requested on CalOSHA Form 300 as required by regulation.

In the event we receive confirmation of any additional lab-confirmed and epidemiologically-linked cases, we will supplement this notice with the same information about any new affected individuals.

{EMPLOYER NAME} take our workplace health and safety obligations very seriously and in addition to this notice, have taken all other steps required by our Coronavirus Prevention Plan (CPP) to prevent further spread of COVID-19 through our workplace, a copy of which is available upon request. We welcome, and by way of this notice, request that you provide any available futher updated guidance on COVID-19 prevention for employers that is available through your agency.

If you have any questions about this notification or if you wish to discuss any matters related to this correspondence please do not hesitate to contact {HR MANAGER OR DESIGNEE AT (NUMBER)}.

{ADD SIGNATURE BLOCK}