City of Portland/Risk Management 1120 SW 5th Ave., Suite 1040 Portland, OR 97204 503-823-5101

Date you

left work:

Date of

injury or illness:

# **Report of Job Injury or Illness**

days off:

a.m.

Workers' compensation claim

Regularly scheduled

**DEPT USE:** 

Emp

# Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line. Your employer will give you a copy.

Time you began work

on day of injury:

What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot)   Left   Right   Nat    What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder currying a 40-pound box of roofing materials)    For   Str.    Str.   Sacc    Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.  Your legal name:   Language preference:   Birthdate:   Gender: M   F    Your mailing address:   Birthdate:   Gender: M   F    Your mailing address:   Work phone:   Occupation:    Name and phone mumber of health insurance company:   Name and address of health care provides and other custodians of claim records to release relevant medical records to the worker' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Natice: Relevant medical records to the worker's compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Natice: Relevant medical records in claude records of print retreatment for the same conditions or of injuries to be same area of the Moyle, A IIIPAA authorization is not required (45 CFR 12/10). Reclaes of HIIV/AIDS records, certain drug and alcohol treatment records, and other creations of printing to flow, A IIIPAA authorization is not required (45 CFR 12/10). Reclaes of HIIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law required (45 CFR 12/10). Reclaes of HIIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law required (45 CFR 12/10). Reclaes of HIIV/AIDS records, certain drug and alcohol treatment records, and other records of printing to the same area of the low printing and the company of the form to the worker. Even if the worker does n	Time of injury or illness:	a.m.	Time you left work:	F	] a.m. ] p.m.	Check h	ere if you	have more	than one			Ins	
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)    Furt												Occ	
extension ladder carrying a 40-pound box of rooting materials      Event	, , , , , , , , , , , , , , , , , , ,											Nat	
Extension ladder carrying a 40-pound box of roofing materials)    Four   Sec   2-erc	What agged it? What was you doin? I maked waking machines to-11 (E111111111111-											Part	
Sec   2002	what caused it? what were you doing? include venicle, machinery, or tool used. (Example: Fell 10 leet when climbing an											Ev	
Information ABOVE this line; date of death, if death accurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.  Your legal name:   Language preference:   Birthdate:   Gender: M   F   Your mailing address:   Occupation:   Names of wintesses:   Name sond wintesses:   Name and phone number of health insurance company;   Name and address of health care provider who treated you for the injury or illness you are now reporting:   Were you be treated in the emergency room?   Yes   No   Were you treated in the emergency room?   Yes   No   By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I suthorize health care providers and other custodinas of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice Relevant medical records include records of prior teatment for the same conditions or of injuries to the same area off the body. A HIPAA authorization is not required ERI (ERI 64.512(I)). Pelease of HIV/AIDS records, certain dng and alcohol treatment records, and other records protected by state and federal law requires separate authorization.  I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.225.  Worker   Complete the rest of this form and give a copy of the form to the worker does not want to file a claim, keep a copy of this form.  Employer legal business name:   FEIN:   Phone:   FEIN:      Employer legal												Src	
Information ABOVE this line; date of death, If death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.  Your legal name:    Vour legal name:													
Your legal name:   Language preference:   Birthdate:   Gender: M   F   Your mailing address:   Home phone:   Work phone:   Occupation:   Names of witnesses:   Name and phone number of health insurance company:   Name and address of health care provider who treated you for the injury or illness you are now reporting:   Were you hospitalized overnight?   Yes   No   Were you treated in the emergency room?   Yes   No   Were you treated in the emergency room?   Yes   No   Were you treated in the emergency room?   Yes   No   Were you treated in the emergency room?   Yes   No   Were you treated in the emergency room?   Yes   No   Were you treated in the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(1)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.  Worker   Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.   Employer   Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.   Employer legal   Phone:   FEIN:    If worker leasing company,   iss client business name:   FEIN:    If worker leasing company,   iss client business name:   FEIN:    Address of principal place of business from which   Nature of business in which worker is/was supervised:   ZIP:    Address of principal place of principal place of business from which   Nature of business in which worker is/was supervised:   ZIP:    Were other workers injured?   Yes   No   OSI1A 300 log case no:    Date employer   Date worker   Worker's   Date worker   Worker's													
Your mailing address:    Home phone:   Work phone:   Occupation:	Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon r											tive upon request.	
Name and phone   Work phone:   Occupation:	Your legal name:				Language prefe		rence:		Birtl	Birthdate:		Gender: M 🗌 F 🗌	
Name and phone number of health insurance company:    Name and phone number of health insurance company:   Were you hospitalized overnight?	Your mailing address:												
Name and phone number of health insurance company:  Were you hospitalized overnight?  Were you hospitalized overnight?  Were you treated in the emergency room?  Yes \ No  By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records include records or prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(1)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records, and other records, and other records, and the records and the records and other records protected by state and federal law requires separate authorization.  I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.  Worker signature:  Employer  Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.  Employer legal business name:  Phone:  FEIN:  Glient FEIN:  If worker leasing company,   Client FEIN:  If worker leasing company,   Client FEIN:  Address of principal place of business from which worker is/was supervised:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Was injury caused by failure of a machine or product, or by a person other than the injured worker?   Yes   No  Were other workers injured?   Yes   No  Were other workers injured?   Yes   No  Date employer   Date worker   Worker's   Date worker   If fatal, date of death:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties und	Home phone: Work phone:				Occupation:			tion:					
Injury or illness you are now reporting:   Were you hospitalized overnight?   Yes   No   Were you treated in the emergency room?   Yes   No   Yes   No   Yes   Sy my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164-512(I)), Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.  I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.    Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.    Employer   Employer	Names of witnesses:												
Were you hospitalized overnight?	Name and phone number												
Were you treated in the emergency room?	injury c								ou are now	reporting:			
By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.  I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.  Worker a long letter of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.  Worker legal business name:  Employer legal place	Were you hospitalized overnight?												
authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(1)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.  I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.  Worker    Complete by	Were you treated in the emergency room?												
Worker signature:    Completed by (please print):   Date:	employer, claim administrator, and the Oregon Department of Consumer and Business Services. <b>Notice:</b> Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.												
Employer  Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.  Employer legal business name:  If worker leasing company, list client business name:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker?  Yes No  Were other workers injured? Yes No  Date worker  No OSHA 300 log case no:  Date mployer knew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.													
Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.  Employer legal business name: Phone: FEIN:  If worker leasing company, I Client FEIN:  Address of principal place of business (not P.O. Box): Insurance policy no.:  Street address from which worker is/was supervised: ZIP: Insurance of business in which worker event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker   Yes No  Were other workers injured? Yes No  OSHA 300 log case no:  Date employer Date worker   Worker's weekly wage: \$ Date worker   If fatal, date of death:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.	signature:			(1	please p	orint):					J	Date:	
Employer legal business name:  If worker leasing company, list client business name:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker?  Yes No  Were other workers injured? Yes No  Date employer Date worker returned to work: weekly wage: \$ Date worker hired: of death:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.	Employer												
business name:  If worker leasing company, list client business name:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker?  Were other workers injured?  Date worker  Date worker  No  OSHA 300 log case no:  Date worker  No  OSHA 300 log case no:  Date worker  No  OSHA 300 log case no:  Date worker knew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.													
If worker leasing company, list client business name:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker? Yes No  Were other workers injured? Yes No  OSHA 300 log case no:  Date employer Date worker worker returned to work: weekly wage: \$ Date worker hired: of death:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.	1 5 0					Phor	ne:			FEIN:			
list client business name:  Address of principal place of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker? Yes No  Were other workers injured? Yes No  Date employer knew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer  Name and title		V.				1 1101	10.						
of business (not P.O. Box):  Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker? Yes No  Were other workers injured? Yes No  Date employer Anew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer Name and title										FEIN:	FEIN:		
Street address from which worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker? Yes No  Were other workers injured? Yes No  Date employer Date worker Worker's Date worker knew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer Name and title	* * *												
worker is/was supervised:  Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker? Yes No  Were other workers injured? Yes No  Date employer Date worker returned to work: Worker's weekly wage: \$ Date worker If fatal, date of death:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer Name and title													
Address where event occurred:  Was injury caused by failure of a machine or product, or by a person other than the injured worker?						ZIP:							
Were other workers injured? Yes No  Date employer	Address where												
Were other workers injured? Yes No  Date employer													
Date employer knew of claim:  By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer  Name and title													
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.  Employer  Name and title	1 3						Date v		Date work	vorker I		,	
Employer Name and title	By my signature, I acknow	ledge I am	responsible for	r notifying my	y worke	rs' comper	sation ins		npany within		nowledge	of the claim. I	
									<u> </u>				
OSUA requirements. Employers must report yearly related fatalities and astastrophes to Oracon OSUA aithor in newspaper													

**OSHA requirements:** Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.



# A Guide for Workers Recently Hurt on the Job

#### How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete Form 801, "Report of Job Injury or Illness," available from your employer and Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," available from your health care provider.

## How do I get medical treatment?

- You may receive medical treatment from the health care provider of your choice, including:
  - ➤ Authorized nurse practitioners
  - > Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - > Oral surgeons
  - > Osteopathic physicians
  - > Physician assistants
  - Podiatric physicians
  - > Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

#### Are there limitations to my medical treatment?

- Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work. Check with your health care provider about any limitations that may apply.
- If your claim is denied, you may have to pay for your medical treatment.

# If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your jobrelated injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

#### What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

### Ombudsman for Injured Workers: An advocate for injured workers

Toll-free: 800-927-1271

Email: oiw.questions@oregon.gov

**Workers' Compensation Resolution Section** 

Toll-free: 800-452-0288

Email: workcomp.questions@oregon.gov

The collection and use of your Social Security number (SSN): You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for the following: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).