saif

400 High St. SE, Salem, OR 97312

**For SAIF Customer Use**
**Area** _____ _____ _____
**Dept.** _____
**Shift** _____ **CC** _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

Email: saif801@saif.com
Toll-free phone: 1.800.285.8525
Toll-free FAX: 1.800.475.7785

# Report of Job Injury or Illness

Workers' compensation claim

## Worker

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

| 1. Date of injury or illness: | 2. Date you left work: | 3. Time you began work on day of injury: ☐ a.m. ☐ p.m. | 4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S | DEPT USE: |
|---|---|---|---|---|
| 5. Time of injury or illness: ☐ a.m. ☐ p.m. | 6. Time you left work: ☐ a.m. ☐ p.m. | 7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m. | | Emp |
| 8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right | | | 9. Check here if you have more than one job: ☐ | Ins |
| 10. 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) | | | | Occ |
| | | | | Nat |
| | | | | Part |
| | | | | Ev |
| | | | | Src |
| | | | | 2src |

***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.***

| 11. Your legal name: | 12. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify): | 13. Birthdate: | 14. Gender: ☐ M ☐ F |
|---|---|---|---|
| 15. Your mailing address, city, state and zip: | | | 16. Home phone: |
| 17. Social Security no. (see back*): | 18. Occupation: | | 19. Work phone: |
| 20. Names of witnesses: | | | |
| 21. Name and phone number of health insurance company: | | 22. Name and address of health care provider who treated you for the injury or illness you are now reporting: | |
| 23. Have you previously injured this body part? ☐ Yes ☐ No | | | |
| 24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No | | | |
| 25. Were you treated in the emergency room? ☐ Yes ☐ No | | | |

**26. By my signature,** I am making a claim for worker's 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.**

| 27. Worker signature: | 28. Completed by (please print): | 29. Date: |
|---|---|---|
| | | |

## Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

| 30. Employer legal business name: City of Astoria | 31. Phone: (503) 298-2434 | 32. FEIN: 936002118 |
|---|---|---|
| 33. If worker leasing company, list client business name: N/A | | 34. Client FEIN: |
| 35. Address of principal place of business (not P.O. Box): 1095 Duane St, Astoria, OR 97103 | | 36. Insurance policy no.: 764122 |
| 37. Street address from which worker is/was supervised: ZIP: | | 38. Nature of business in which worker is/was supervised: |
| 39. Address where event occurred: | | |
| 40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No | | 41. Class code: |
| 42. Were other workers injured? ☐ Yes ☐ No | 43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No | 44. OSHA 300 log case no: |

| 45. Date employer knew of claim: | 46. Worker's weekly wage: $ | 47. Date worker hired: | 48. If fatal, date of death |
|---|---|---|---|
| 49. Return-to-work status: Not returned ☐ | ☐ Regular Date: | ☐ Modified Date: | 50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No |

**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.**

| 51. Employer signature: | 52. Name and title (please print): | 53. Date: |
|---|---|---|
| | | |

**801**
X801 1/17

**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.

RESET

PRINT

# A guide for workers recently hurt on the job

The following information is provided by SAIF at the request of the Workers' Compensation Division

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## 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 Physician'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
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - 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 job-related 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?

- SAIF or your employer should be able to answer your questions. Call SAIF at 800.285.8525.
- 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 Compliance Section**

  Toll-free: 800.452.0288

  Email: workcomp.questions@oregon.gov

* **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, 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: 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).

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