SAIF CORPORATION
400 High Street, S.E., Salem, OR 97312-1801

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

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

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 Corporation, 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. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right		9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)			
11. Name of witnesses:		12. Have you previously injured this body part? ☐ Yes ☐ No	
13. Your legal name:		14. Birthdate:	15. Gender: ☐ M ☐ F
16. Mailing address, city, state and zip:			17. Home phone:
18. SSN (See #25 below):	19. Occupation:		20. Work phone:
21. Name of physician or health-care professional:		22. If medical treatment was given away from the worksite, print name and address of facility:	
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
24. Were you treated in the emergency room? ☐ Yes ☐ No			

25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers 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 require separate authorization.

I authorize the use of my SSN in the processing of this claim. (Authorizing the use of your SSN will ensure prompt processing of your claim and that your medical records are not released to unauthorized parties. If you do not authorize the use of your SSN, check here ☐ .)

26. Worker signature:	27. Completed by (please print):	28. Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation 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.

29. Employer legal business name: Oregon Military Department	30. Phone: AGP (503) 584-3581	31. FEIN: 93-6001775
32. If worker leasing company, list client business name: N/A		33. Client FEIN: N/A
34. Address of principal place of business (not P.O. box): 1776 Militia Way SE, Salem, OR 97309		35. Insurance policy no.: 155927
36. Street address from which worker is/was supervised: ZIP:		37. Nature of business in which worker is/was supervised: Government
38. Street address, city, and state where event occurred:		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		40. Class code: 9499
41. Were other workers injured? ☐ Yes ☐ No	42. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No	43. OSHA 300 log case #:
44. Date employer knew of claim:	45. Worker's weekly wage: $	46. Date worker hired: / 47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature:	51. Name, title, and phone (please print): Robin Webb, Safety Officer (503) 584-3581	52. Date:

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OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

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Understanding workers' compensation claims
A guide for workers recently hurt on the job

With some exceptions you must file a workers' compensation claim with your employer within 90 days of injury or within one year of learning you have an occupational injury or illness. Failure to do so may result in denial of the claim. Knowingly making a false statement or representation for the purpose of obtaining a benefit or payment is punishable by law.

Form 801 is your receipt that you gave notice of a claim. Keep a copy as your record. Your employer is required to submit your claim to its insurer within five days. The insurer must notify you of its acceptance or denial of your claim within 60 days after the date your employer knows of your claim. If your employer is self-insured, the acceptance or denial notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. If your claim is denied, the reason for the denial and your rights will be explained.

If you have questions, contact your employer's workers' compensation insurer. If you do not know who your insurer is, call the Employer Index in Salem at (503) 947-7814 or toll-free (888) 877-5670.

If you have a disabling claim, your insurer will send you a brochure called *"What happens if I'm hurt on the job?"* that should answer many of your questions. If you still have questions, call the Ombudsman for Injured Workers for help understanding your rights and responsibilities: (503) 378-3351, (800) 927-1271, or TTY (503) 947-7189. For general information about benefits, call the Workers' Compensation Division at (503) 947-7585, (800) 452-0288, or TTY (503) 947-7993.

Tell your doctor or authorized nurse practitioner that you were hurt on the job.
Your doctor or authorized nurse practitioner will ask you to fill out a Form 827 – *"Worker's and Physician's Report for Workers' Compensation Claims."* Your doctor or authorized nurse practitioner will send the Form 827 to the insurer for you.

May I get treatment from any doctor?
Unless the insurer has enrolled you in a managed-care organization (MCO), you may treat with any medical provider who qualifies as an "attending physician" under Oregon law or any authorized nurse practitioner. Your attending physician or authorized nurse practitioner is primarily responsible for your care and will tell you if there are any limits to the services he or she can provide.

Only your attending physician or authorized nurse practitioner can authorize time off work, reduce your work hours or duties, or release you to go back to work.

Who will pay my medical bills?
If your claim is accepted, the insurer will pay medical bills related to the medical condition they accepted in writing. **Save your receipts** for prescription medications, transportation, and other bills you pay for treatment related to the medical condition the insurer accepted. You may then request reimbursement in writing from the insurer.

Bills are not paid if your claim is denied or if the bills are related to a condition other than that accepted in writing by the insurer. Contact the insurer if you have questions.

If I can't work, will I receive payments for lost wages?
You will receive temporary disability payments if your attending physician or authorized nurse practitioner notifies the insurer that you **cannot work** due to your injuries or releases you to modified work that results in a loss of wages. Generally, you will not be paid for the first three calendar days of lost wages. However, you may receive payment for those three days if you are not released to do any type of work for at least 14 days from the time you left work, or if you were admitted to a hospital during your first 14 days of total disability.

If you have another job, you may be eligible to receive supplemental disability payments. To receive these benefits, you must notify the insurer about your other job(s) **within 30 days of the insurer's receipt of your initial claim** and provide proof of wages paid to you on the other job(s) (i.e., check stubs or payroll records).

What can I do to make sure I receive benefits to which I am entitled?

- **Find out the legal business name of your employer** and the name of its workers' compensation insurer. The Employer Index can help you identify the insurer if the employer is known.
- **Keep all medical appointments** and follow your attending physician's or authorized nurse practitioner's instructions.
- **Read and keep copies** of all letters and forms you receive regarding your claim.
- **Keep notes** of phone calls, including with whom you speak, subject matter, and dates.
- **Observe all deadlines.** Do not be late to submit information or to file appeals.
- **Contact your employer** immediately when your doctor releases you for work.
- **If you have questions** about your claim that are not resolved by your employer or insurer, contact the Ombudsman for Injured Workers at (800) 927-1271.