|  |  |
| --- | --- |
| *Insert self-insured employer and insurer name, address, phone number, and service company, if any.* | **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 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. |
| Date of injury or illness:  | Date youleft work:  | Time you began work on day of injury:  | **[ ]** a.m.**[ ]** p.m. | Regularly scheduled days off:**[ ] [ ] [ ] [ ] [ ] [ ] [ ]** M T W T F S S | **Dept Use:**  |
| Emp |
| Time of injury or illness: | **[ ]** a.m.**[ ]** p.m. | Time you left work:   | **[ ]** a.m.**[ ]** p.m. | Check here if you have more than one job: **[ ]**  |
| Ins |
| What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) **[ ]** Left [ ] Right | Occ |
| Nat |
| 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)  | 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.***  |
| Your legal name:  | Language preference:  | Birthdate:  | Gender: M **[ ]**  F **[ ]**  |
| Your mailing address:  | Home phone:  |
| Social Security no. (see Form 3283):  | Occupation:  | Work phone:   |
| 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 |
| **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.  |
|
|
|
|
| Workersignature:  | Completed by (please print):  | Date:  |
|
|
| **Employer**Complete the rest of this form and give a copy of the form to the worker. Notify your workers’ compensation insurance company 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. |
| Employer legal business name:  | Phone:  | FEIN:  |
| If worker leasing company,list client business name:  | Client FEIN:  |
| Address of principal place of business (not P.O. Box):  | Insurance policy no.:  |
| Street address from which worker is/was supervised:  | ZIP:  | Nature of business in which worker is/was supervised: |
| Address whereevent 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 knew of claim:  | Date worker returned to work:  | Worker’s weekly wage: $      | Date worker hired:  | If fatal, date of death: |
| Employer signature: | Name and title (please print): | Date:  |
| 440-801 (01/16/DCBS/WCD/WEB) | **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.  | **801** |