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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *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 you  left 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. | | | | | | | | | | | | | | | | | | | | | | | | | |
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|
| Worker  signature: | | | | | | | 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 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  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** |