



Workers' Compensation Division

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL	WCD employer no.:
	Policy no.:

Note to Provider: Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.

Worker or provider	Worker's legal name, street address, and mailing address:	Language preference:	Male/female <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security no. (see Form 3283):	Dept. Use Ins. no.
	Phone:	Claim no. (if known):	Date/time of original injury:		Nature
		Date of birth:	Occupation:	Last date worked:	Part
	Employer at time of original injury — name and street address:	Health insurance company name and phone:			Event
	Phone:	Workers' compensation insurer's name, address:			Source

Worker: Check reason for filing this form, answer questions (if any), and sign below.

Worker	<input type="checkbox"/> First report of injury or disease (Do not complete or sign if you do not intend to make a claim.) Have you injured the same body part before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____	Check here if you have more than one job. <input type="checkbox"/>
	<input type="checkbox"/> Request for acceptance of a new or omitted medical condition on an existing claim Condition: _____	Describe accident:
	<input type="checkbox"/> Notice of change of attending physician or nurse practitioner Reason for change: _____	
	<input type="checkbox"/> Report of aggravation of original injury (actual worsening of a compensable condition)	

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

_____ **Worker's signature** _____ **Date**

Provider: If worker initiated this report, give worker a copy immediately.

Provider	If the worker filed this report for:		To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov To order supplies of this form, call 503-947-7627.
	<ul style="list-style-type: none"> First report of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit. New or omitted medical condition – Attach chart notes, including diagnostic codes. Send this form to the insurer within five days of visit. Change of attending physician or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: <input type="checkbox"/> I request insurer to send its records. Aggravation of original injury – Sign this form and send it to insurer within five days of visit. 		
	If filing for progress report, closing report, or palliative care request, check the appropriate box below.		
	<input type="checkbox"/> Progress report OR <input type="checkbox"/> Closing report (See instructions in Bulletin 239.) <input type="checkbox"/> Palliative care request – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.		

Provider	a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Next appointment date:	Est. length of further treatment:	If yes, name hospital:
		Current diagnosis per ICD-10-CM codes:		
	b	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____
		Work ability status:		
		<input type="checkbox"/> Regular work (job at injury) authorized start (date): _____	through (date, if known): _____	
		<input type="checkbox"/> Modified work authorized from (date): _____	through (date, if known): _____	
		<input type="checkbox"/> No work authorized from (date): _____		
	c	Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		

Provider's name, degree, address, and phone: (<i>print, type, or use stamp</i>) _____ <input checked="" type="checkbox"/> _____ Provider's signature _____ Date	— Original and one copy to insurer — Retain copy for your records — Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner
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