ORS 656.325(2)
OAR 436-060-0105 Suspension Checklist

Chapter 436, Division 060, Claims Administration, effective July 1, 2024

INSANITARY OR INJURIOUS PRACTICES, REFUSAL OF TREATMENT OR FAILURE TO PARTICIPATE IN REHABILITATION

Claimant_____Claim Number_____

Claim status:_____Deferred_____Accepted_____Denied_____Partial Denial

DEMAND LETTER

1._____ The demand letter must require the worker to immediately cease actions which imperil or delay recovery OR to immediately begin to change inappropriate behavior and participate in activities needed to help recovery ***0105(2)***
Such actions include:

_____ insanitary or injurious practices

_____ refusing necessary medical or surgical treatment

_____ failing to participate in a physical rehabilitation program

2._____ Describe the unacceptable actions ***0105(2)(a)***

3._____ Tell why such conduct is inappropriate and explain how it is harmful or is delaying recovery ***0105(2)(b)***

4._____ Give the date by which inappropriate actions must stop or appropriate actions must begin; specifically describe what the worker must do to comply ***0105(2)(c)***

5._____ The warning paragraph in bold and formatted as follows ***0105(2)(d)(B)****

If you continue this inappropriate conduct after the above date:

- We will ask that your workers' compensation benefits be suspended, and

- Your permanent disability award, if any, may be reduced under ORS 656.325 and OAR 436-060.

6._____ If represented, simultaneously send a copy to the worker's attorney ***0105(2)***

7._____ Simultaneously send a copy to the worker's attending physician ***0105(2)***

SUSPENSION REQUEST

1._____ Copy of request, including all attachments, sent by registered, certified, or personal service to worker ***0105(4)(a)***

2._____ If represented, copy of request, including all attachments, simultaneously sent by registered, certified, or personal service to worker's attorney ***0105(4)(a)***

3._____ State request is being made under ORS 656.325 and OAR 436-060-0105 ***(4)(b)(A)***

4._____ Describe the worker's actions that prompted the request and state whether the actions continue ***0105(4)(b)(B)***

5._____ State any reasons the worker gave to explain their actions OR state the worker has not provided any reason ***0105(4)(b)(C)***

6._____ State how, when, and with whom the worker's failure to comply or refusal to comply was verified ***0105(4)(b)(D)***

7._____ Attach a copy of the original demand letter ***0105(4)(b)(E)***

8._____ Any other relevant information, including, but not limited to, chart notes, surgery or physical therapy recommendations/prescriptions, and all physician or authorized nurse practitioner recommendations ***0105(4)(b)(F)***

9._____ The notice to worker in bold and formatted as follows ***0105(4)(b)(G)(ii)****

Notice to worker:

If the Workers' Compensation Division decides to suspend your benefits and you do not correct your unacceptable actions, or show us a good reason why they are acceptable, we will close your claim.

If you think this request to suspend your benefits is wrong, write to the Workers' Compensation Division immediately.

- Your letter must be mailed within 10 days of the date this request was mailed or personally served on you.

- Address your letter to:

Workers' Compensation Division
350 Winter Street NE
PO Box 14480
Salem OR 97309-0405

If you have any questions, you may call the Workers' Compensation Division at 800-452-0288 (toll-free) or 503-947-7585.

*The mandatory language in this checklist must be used no later than Oct. 1, 2024. See OAR 436-060-0105(2)(d) and OAR 436-060-0105(4)(b)(G) for more information.