

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: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regularly scheduled days off: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	DEPT USE:
Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Check here if you have more than one job: <input type="checkbox"/>	M T W T F S S	Emp
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) <input type="checkbox"/> Left <input type="checkbox"/> Right				Ins
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)				Occ
				Nat
				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 <input type="checkbox"/> F <input type="checkbox"/>
Your mailing address:			
Home phone: _____			
Home phone: Social Security no. (see Form 3283): _____	Work phone: Occupation: _____	Work phone: Occupation: _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>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.</p> <p>I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.</p>			
Worker signature:	Completed by (please print):	Date:	

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.		
Employer signature:	Name and title (please print):	Date:

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.

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