INJURY/ACCIDENT REPORT

This report must be completed within 24 hours of an accident involving an injury to students, employees or visitors. Send completed reports to Leland Bliss at the District office. Attach additional pages if necessary.

1. **WHO WAS INJURED? (check one)** ☐ Student ☐ Employee ☐ Visitor
   Name of Injured Person:
   Home Address:
   City, State & Zip:
   Home Telephone No.:
   Sex: ☐ Male ☐ Female
   Date of Birth:
   Employee Job Title or Occupation:

2. **WHEN AND WHERE DID THIS HAPPEN?**
   Date of Injury: Time Injury Occurred:
   Date Reported: Time Reported:
   Name of Parent/Guardian/Spouse Notified:
   Who made the notification and when?
   Did injury occur on District property? ☐ Yes ☐ No
   Describe the exact location where the injury occurred:

3. **HOW DID THIS HAPPEN?** What was the injured person doing at the time of the injury? Describe the events immediately preceding the injury. Identify any employees involved in the accident and any tools, machinery, equipment, or vehicles involved. (Attach photos.)

4. **WHAT INJURIES RESULTED?** Type of injuries and body part(s) injured. Example: "Sprained arm."

5. **DID ANYONE SEE THE INJURY HAPPEN?** Name(s) and phone numbers of witness(es) if any. (Attach statement of each witness.)

6. **DID ANYONE ELSE CAUSE THIS INJURY?** Other person(s) that caused or contributed to the injury, if any.
   Name:
   Home Address:
   City, State & Zip:
   Home Telephone No.:
   Was an arrest made: ☐ Yes ☐ No

7. WAS MEDICAL TREATMENT NEEDED?

Was first aid administered? ☐ Yes ☐ No

Name:

Did injured party go to a hospital/clinic? ☐ Yes ☐ No

Describe medical treatment received:

Did a supervisor accompany injured person? ☐ Yes ☐ No

Name:

Doctor's Name:

Name of hospital/clinic:

Telephone No.:

Injured Person's Signature Date

Supervisor's Signature Date

saifcorporation
400 High Street, S.E., Salem, OR 97312-1801

For SAIF Customer Use
Area _____ _____ _____
Dept. _____
Shift _____ CC _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

Toll Free Phone: 1-800-285-8525
Toll Free FAX: 1-800-475-7785

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 to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness:	2. Date you left work:	3. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right		9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)			
11. Name of witnesses:		12. Have you previously injured this body part? ☐ Yes ☐ No	
13. Your legal name:		14. Birthdate:	15. Gender: ☐ M ☐ F
16. Mailing address, city, state and zip:			17. Home phone:
18. SSN (See #25 below):	19. Occupation:		20. Work phone:
21. Name of physician or health-care professional:		22. If medical treatment was given away from the worksite, print name and address of facility:	
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
24. Were you treated in the emergency room? ☐ Yes ☐ No			
25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers 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 require separate authorization.			
26. Worker signature:	27. Completed by (please print):		28. Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation 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.

29. Employer legal business name:	30. Phone:		31. FEIN:
32. If worker leasing company, list client business name:			33. Client FEIN:
34. Address of principal place of business (not P.O. box):			35. Insurance policy no.:
36. Street address from which worker is/was supervised: ZIP:			37. Nature of business in which worker is/was supervised:
38. Street address, city, and state where event occurred:			
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No			40. Class code:
41. Were other workers injured? ☐ Yes ☐ No	42. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No		43. OSHA 300 log case #:
44. Date employer knew of claim:	45. Worker's weekly wage: $	46. Date worker hired:	47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:			49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature:	51. Name, title, and phone (please print):		52. Date:

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X801 1/08

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

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saifcorporation
400 High St SE, Salem, OR 97312

A guide for workers recently hurt on the job

How do I file a claim?

- Notify your employer about your job-related injury or illness as soon as possible.
- Ask your employer to give you **Form 801, "Report of Job Injury or Illness,"** and complete Form 801.
- Ask your employer the name of its workers' compensation insurer.
- Get medical treatment from a health care provider **of your choice** and tell your provider that you were injured on the job. Your employer cannot choose your health care provider for you.
- Your health care provider should ask you to complete **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims."**

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice,** including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified or light duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- You may also call any of the numbers below:

Ombudsman for Injured Workers:
An advocate for injured workers
Toll-free: 800.927.1271
Email: oiw.questions@state.or.us

Workers' Compensation Infoline:
Benefit Consultants
Toll-free: 800.452.0288
Email: workcomp.questions@state.or.us

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

440-3283 (1/07/DCBS/WCD/WEB) for distribution with X801 SAIF Corporation 2/07