

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 (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. day of injury: (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		4. 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"/> M T W T F S S	
5. Time of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		6. Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		7. Check here if you are employed by more than one employer: <input type="checkbox"/>			
8. 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		9. Worker's language preference other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Your legal name:				14. Birthdate:		15. Gender: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
24. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> 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: High Desert ESD		30. Phone: 541.693-5606		31. FEIN: 93-6002511	
32. If worker leasing company, list client business name:				33. Client FEIN:	
34. Address of principal place of business (not P.O. box): 2804 SW 6th St, Redmond, OR 97756				35. Insurance policy no.: 246652	
36. Street address from which worker is/was supervised: ZIP:				37. Nature of business in which worker is/was supervised: Education District	
38. Street address, city, and state where event occurred:				40. Class code:	
39. 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					
41. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		42. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Not returned <input type="checkbox"/> Regular Date: <input type="checkbox"/> Modified Date:				49. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
50. Employer signature:		51. Name, title, and phone (please print):			52. Date:

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.**