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: High Desert ESD	30. Phone: 541.923.8249	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): 145 SE Salmon Ave, 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:
38. Street address, city, and state where event occurred:		Education District

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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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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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.**

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