Workers' Compensation Forms

1. **Employee Injury/Incident Reporting Form:** have employee complete this form for all incidents (aside from minor injuries that simply require first aid). The employee is to submit the form to their supervisor, the supervisor should review and sign. Make a copy of this form for your file and send the original to Teri Lowery (within 24 hours!!).

2. **Supervisor's Accident Investigation Form:** the accident must be investigated, have the supervisor fill out this form, sign and send with the Employee Injury form.

3. **A Guide for Workers Recently Hurt on the Job:** if the employee is filing a claim, give them this guide to instruct them on how to file a claim.

4. **Report of Injury or Illness (801) form:** the employee must fill out the top portion of this form and sign if filing a claim. Send this to Teri Lowery along with the Employee Injury and Supervisor's Form. **Only complete the 801 form if medical attention is being sought.**

5. **Release to Return to Work Form & Card:** if the employee requires medical attention, please have them take this form (and the card attached) to the attending physician. Make sure they understand it's very important that this form be presented to the physician. This lets us know if there are any work restrictions if they are able to return to work or if they are unable to return to work. The attached card is for the physician, this makes it easier on the employee as it provides all of the necessary information.

SWEET HOME SCHOOL DISTRICT

Employee Injury/Incident Reporting Form

To be completed by Employee

Please complete immediately following the injury/incident (if possible) and submit to your supervisor

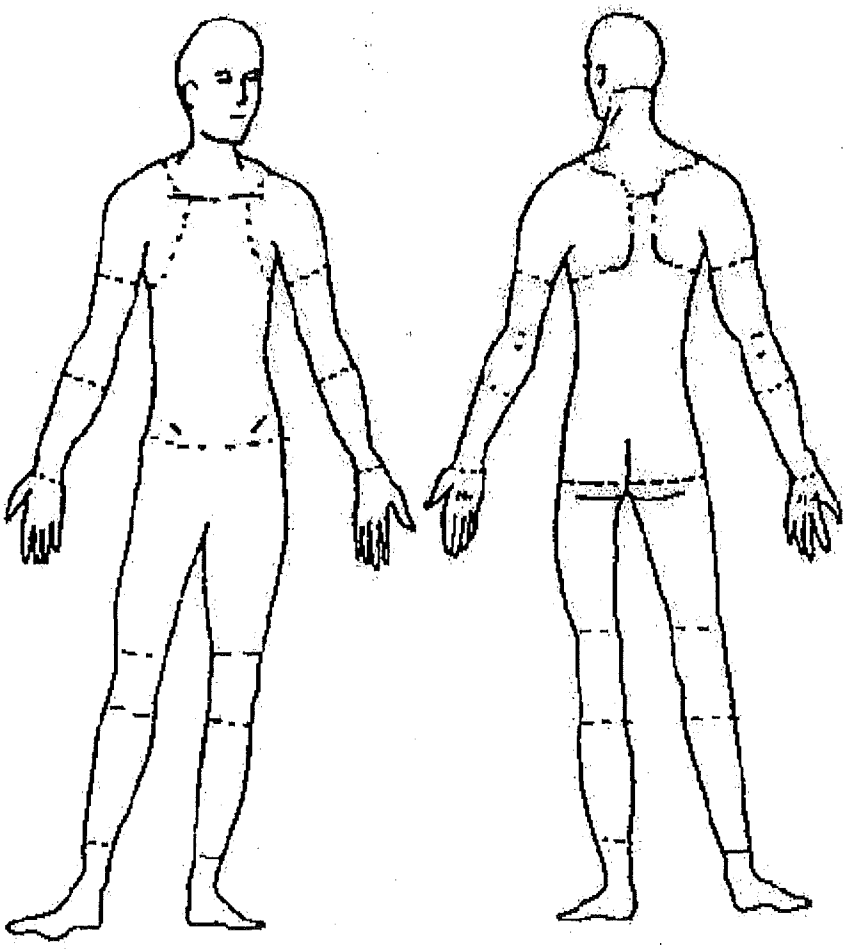
Section 1: BACKGROUND

Injured Worker's Name:	*Job Title:*
School:	*Date Form Completed: ___/___/____*
WITNESS 1 *Name:* *Job Title:*	*WITNESS 2* *Name:* *Job Title:*
WHEN did the accident occur: *Date:___/___/____* *Time:___:___am/pm*	*WHEN was the accident reported to the Supervisor?* *Date:___/___/____* *Time:___:___am/pm*
WHERE did the accident/incident occur?	*Equipment, materials, or chemicals involved:*

Section 2: DESCRIPTION OF INCIDENT

Describe the accident fully. Include the sequence of events leading up to the incident as well as the specific activity engaged in when the incident occurred (write on back of form, if necessary).
Describe the injury (include body part affected/left or right):
Sections 1 & 2 prepared by: *Date___/___/____* *Signature:*
Supervisor Signature: *Date___/___/____*

Part of body affected (shade all that apply):



Additional Information:

saifcorporation

Risk Management **Incident form**
www.saif.com

☐ Near-Miss
☐ First Aid

FILE 801, IF BOXES BELOW ARE CHECKED
☐ Medical Care
☐ Time Loss
☐ Fatal

SYSTEM CHALLENGES

Management
Do we have:
Policy Enforcement
Hazard Recognition
Accountability
Supervisor Training
Corrective Action
Production Priority
Proper Resources
Job Safety Training
Hiring Practices
Maintenance
Adequate Staffing

Employee
Was the employee:
Following Procedure
Training
Previous Injury
Mental Ability
Physical Capacity
Equipment Use
Short Cuts
PPE Worn
Safety Attitude

Equipment
Do we have:
Proper Tool Selection
Tool Availability
Maintenance
Visual Warnings
Guarding

Environment
What about:
Plant Layout
Chemical
Temperature
Noise
Radiation
Weather
Terrain
Vibration
Ergonomics
Lighting
Ventilation
Housekeeping
Biological

Additional Causal Factors:
☐ Faulty Equipment
☐ Non-Employee
☐ Prior Injury
☐ Late Reporting
☐ Off-the-Job Injury
(Explain any checked boxes on separate sheet)

Incident form

Immediate supervisor should complete this form promptly with worker.

Company Name: _____

Employee: _____

Occupation/Department: _____

Where Incident Occurred: _____ Date/Time: _____ AM/PM

If injury, describe (Nature/Body part) _____

Treatment: ☐ None ☐ First Aid Only ☐ Doctor ☐ Hospital

Treating Physician: _____

Phone: _____

Witnesses: _____

Describe Accident/Incident Fully:

Identify factors which contributed to or caused accident (refer to list on left side of page):

Management:	**Employee:**
Equipment:	**Environment:**

Counter measures/best practices to prevent reoccurrence:	**Who**	**By When**

Safety Committee Review Date: _____

If accident/incident was caused by a person not employed by us, who?
Name: _____ Phone: _____
(Attach additional sheet if needed)

Date: _____ _____
Supervisor's Signature

Note: Complete entire Workers Compensation claim (Form 801 or 801s) if injury required doctor's treatment. Form 801 or 801s must be received by SAIF within five (5) days of your knowledge of doctor treatment If needed, complete Employer's Page (Page 1) of 801 for OSHA recordkeeping requirements.

This form DOES NOT meet OSHA recordkeeping requirements.

Completing the Accident/Incident Analysis

All close calls, near-misses, incidents, and accidents should be analyzed for corrective action regardless of severity. Time and distance work against a thorough analysis as most people quickly forget important facts and key details.

Distance from the incident means loss of visual information, so complete the analysis at the scene as soon as possible. The S-767 should be completed by the immediate supervisor of the person(s) directly involved in the incident. A manager, safety committee, safety coordinator or analysis team can assist in the absence of the immediate supervisor. The S-767 asks no questions other than a brief description of an injury, if one occurred. Questions often provide closed answers, so the key items on the analysis document are designed to encourage open dialogue and communication about facts and details. This is the primary opportunity for those involved to gather key information for preventing similar incidents in the future.

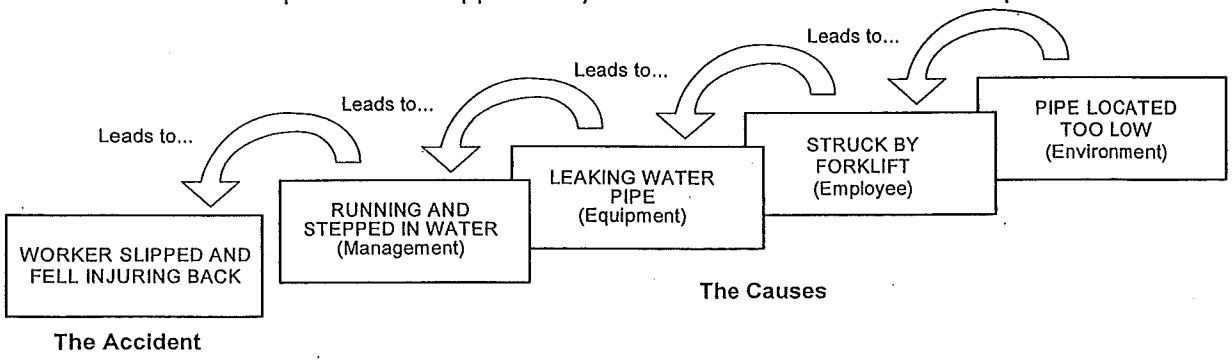
A Successful Analysis Process: The person(s) conducting the analysis need to look at the systems/ procedures/policies within the business that are not working and may have contributed in some way to the incident. Even minor contributions should be listed. The systems to review are: Management, Employee, Equipment, and Environment (MEEE). Review system items shown in the left margin of the Accident/Incident Analysis form **in relation to the incident.** These are areas to explore within these systems, they are not questions. Once the contributing system elements are identified, write them in the Counter measures/best practices box along with any other system changes that will prevent recurrence.

First Step - Care for the injured: Insure appropriate medical care or first aid is provided for anyone injured.

Second Step - Secure the scene of the accident: Make certain that key evidence is preserved so that all pertinent facts of the accident can be determined. In the case of serious accidents, photographs of the scene are a valuable tool in determining causes, particularly if the area needs to be put back in order quickly. Note the position of equipment and materials, presence or lack of equipment safeguarding, specific materials and chemicals involved, warning signs and any other physical evidence.

Third Step - Interview witnesses: Witnesses to the accident or persons having knowledge valuable to the analysis should be met with individually. Emphasis should be placed on determining the facts, not on placing blame. If the injured employee(s) is/are not seriously injured, they should be interviewed while awaiting transport for medical treatment. All questions should be open-ended (who, what, when, where, how and why), to encourage a detailed account of the facts. Yes and No questions should be avoided.

Fourth Step - Analyze data to determine causes and best practices to prevent recurrence: Refer to your notes from the scene of the accident and witness interviews. Work backwards from the accident to trace all causes to their source. It is helpful to have multiple people involved in determining possible solutions. Each cause identified presents an opportunity for intervention to reduce the potential for future accidents:



Fifth Step - Follow up on corrective actions: This is usually the function of the safety coordinator or safety committee. At the next safety committee meeting, any accident analysis reports should be reviewed to ensure appropriate corrective actions (Countermeasures/Best Practices) were identified. Furthermore, steps should be taken to ensure that these actions have been implemented at the site of the accident as well as in any other areas appropriate in the organization. Any accidents or incidents occurring, for which a report was not completed, should be referred to the appropriate person responsible for completion of the report.

A guide for workers recently hurt on the job

The following information is provided by SAIF Corporation at the request of the Workers' Compensation Division

saifcorporation
400 High St. SE, Salem, OR 97312

How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims,"** available from your health care provider.

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.

Are there limitations to my medical treatment?

- **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.**

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?

- SAIF Corporation or your employer should be able to answer your questions. Call SAIF Corporation at 800.285.8525.
- If you have questions, concerns, or complaints, 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 Compliance Section

Toll-free: 800.452.0288

Email: workcomp.questions@state.or.us

* **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (01/10/DCBS/WCD/WEB) for distribution with X801 SAIF Corporation 1/10

saifcorporation
400 High St. SE, Salem, OR 97312

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

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

Email: saif801@saif.com
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. Time you began work on day of injury: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐M ☐T ☐W ☐T ☐F ☐S ☐S	DEPT USE:
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.		Emp
				Ins
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right			9. Check here if you have more than one job: ☐	Occ
				Nat
10. 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)				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.

11. Your legal name:	12. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	13. Birthdate:	14. Gender: ☐ M ☐ F
15. Your mailing address, city, state and zip:			16. Home phone:
17. Social Security no. (see back*):	18. Occupation:		19. Work phone:
20. Names of witnesses:			
21. Name and phone number of health insurance company:		22. Name and address of health care provider who treated you for the injury or illness you are now reporting:	
23. Have you previously injured this body part? ☐ Yes ☐ No			
24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
25. Were you treated in the emergency room? ☐ Yes ☐ No			

26. By my signature, I am making a claim for worker's 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 Businesss 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.

27. Worker signature:	28. Completed by (please print):	29. 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.

30. Employer legal business name:	31. Phone:	32. FEIN:
33. If worker leasing company, list client business name:		34. Client FEIN:
35. Address of principal place of business (not P.O. Box):		36. Insurance policy no.:
37. Street address from which worker is/was supervised: ZIP:		38. Nature of business in which worker is/was supervised:
39. Address where event occurred:		
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		41. Class code:
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No	44. OSHA 300 log case no:

45. Date employer knew of claim:	46. Worker's weekly wage: $	47. Date worker hired:	48. If fatal, date of death
49. Return-to-work status: Not returned ☐ ☐ Regular Date: ☐ Modified Date:			50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
51. Employer signature:	52. Name and title (please print):		53. Date:

801
X801 4/11

OSHA requirements: On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.

801

Return form to:
Sweet Home School Dist. #55
Fax# 541-367-7104

RELEASE TO RETURN TO WORK

Name of worker	Claim number

Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? ☐ Yes ☐ No If yes, date: _____ (Provide closing information and complete Form 827.)
   If no, estimated medically stationary date: _____ Are there permanent restrictions? ☐ Yes ☐ No ☐ Unknown
   Next scheduled appointment date: _____
2. Worker is released to:
   ☐ full duty without limitations Date: _____ (Do not complete lines 3 through 11. Sign below.)
   ☐ modified duty from (date): _____ through (date): _____ (specify limitations below)
   ☐ modified hours specify hours: _____ from (date): _____ through (date): _____
   ☐ not released to work Est. RTW date: _____ If modified release, provide date of anticipated regular release: _____

Hours:	No limitations	1	2	3	4	5	6	7	8	Other (specify)
3. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can stand/walk a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
4. At one time, worker can stand/walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
5. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can sit a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
6. At one time, worker can sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:

	Right	Left	
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No	Dominant hand
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No	
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:

	Continuous 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Climb	☐	☐	☐	☐	☐
g. Balance	☐	☐	☐	☐	☐
h. Reach	☐	☐	☐	☐	☐
i. Push/pull	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of medical service provider*	Printed name	Date

440-3245 (10/05/DCBS/WCD/WEB)

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.

Employer:
Sweet Home School Dist 55
1920 Long Street
Sweet Home, OR 97386

saifcorporation
400 High St. SE
Salem, OR 97312

Policy #: 760407

Employer Contact#: Cindy Bell 541-367-7112

Please give this card to your doctor if you seek
Medical treatment for an on-the-job injury or illness