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| LibertyNorthwestBlack | | | | | | | | | | PO Box 4555  Portland, OR 97208-4555  800-929-4732  **LNW 801 Fax: 800-259-8675** | | | | | | | | | | | | | **Report of Injury or Illness**  Workers’ Compensation Claim | | | | | | | | | | | | | | | |
| Claim number: | | | | | | | | | | | Location code: | | | | |
| 1. Worker’s legal name and mailing address: | | | | | | | | | | | | | | | | 2. Date of injury/illness: | | | | | | | | | 3. Time of injury/illness:  a.m.  p.m. | | | | | | | | | | 4. Last date worked: | | | |
| 5. Date of birth: | | | | | | | | | 6. Gender:  Male  Female | | | | | | | 7. SSN (see form 3283): | | | | | | |
|  | | | | | | | | Worker’s phone number: | | | | | | | | 8. Were you hospitalized as an in-patient?  Yes  No | | | | | | | | | | | | | | | 9. Were you treated in the ER?  Yes  No | | | | | | | |
| 10. What is your injury/illness? What part of body? Which side? (Example: sprained right foot)  Right  Left | | | | | | | | | | | | | | | | | | | | | | | | | | 11. Language Preference: | | | | | | | | | | | **DEPT USE:** | |
| 12. Has body part been injured before? (if yes, explain)  Yes  No | | | | | | | | | | | | | | 13. Occupation (job title): | | | | | | | | | | 14. Name of personal health insurer: | | | | | | | | | | | | | Emp no | |
| 15. Name of first medical provider who treated injury/illness:    Phone: | | | | | | | | | | | | | | | | | | 16. Name of regular doctor:    Phone: | | | | | | | | | | | | | | | | | | | Ins | |
| Occ | |
| 17. 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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Nat | |
| Part | |
| Ev | |
| Src | |
| Witnesses (if any): | | | | | | | | | | | | | | | Check here if you are employed w/more than one employer. | | | | | | | | | | | | | | | | | | | | | | 2src | |
| **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 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 require separate authorization. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Worker  signature: | | | | | | | | | | | | | | | | | | | Completed by  (please print): | | | | | | | | | | | | | | | | | Date: | | |
| **Employer:** Complete the rest of this form and give a copy of the form to the worker. Notify your workers’ compensation insurance company within five days of knowledge of the claim. Even if the worker does not file a claim, maintain a copy of this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. Employer’s legal business name:  Confluence Environmental Center | | | | | | | | | | | | | | | | | | | | | 19. Date of hire: | | | | | | | | | | 20. State of hire: | | | | | | | |
| 21. Immediate supervisor’s phone: | | | | | | | | | | | | 22. Personnel/HR phone: | | | | | | | | | 23. Insurance policy no.  WC41NC018984011 | | | | | | | | | | 24. Payroll class code: | | | | | | | |
| 25. Department and street address where event occurred:  Is this your business location?  Yes  No | | | | | | | | | | | | | | | | | | | | | 26. Employer’s business address, if different from # 25: 5441 SE Belmont Ave., #E205, Portland, OR 97215 | | | | | | | | | | | | | | | | | |
| 27. Client’s name, if employer is leasing co. or temporary agency: | | | | | | | | | | | | | | | | | | | | 30. Was injury caused by person other than injured worker? | | | | | | | | | | | | | | | | | | Yes  No |
| 31. Was injury caused by failure of machinery or product? | | | | | | | | | | | | | | | | | | Yes  No |
| 28. Client phone: | | | | | | | | | | | | | | | | | | | | 32. Were other workers injured? | | | | | | | | | | | | | | | | | | Yes  No |
| 33. Is the worker “premium exempt” (a Preferred Worker)? | | | | | | | | | | | | | | | | | | Yes  No |
| 29. Client FEIN: | | | | | | | | | | | | | | | | | | | | (If yes, attach a copy of eligibility card or “Notice of Premium Exemption.”) | | | | | | | | | | | | | | | | | | |
| 36. Wage & wage period: | | | | | | | |  | | | | |  | | | | | |
| 34. Scheduled days off: | | | | | | | | | | | 35. No. of days worked per week: | | | | | | | | |  | | | | | | | | Per | | | | | Hr  Day | | | | | |
|  |  | |  |  |  |  |  | | | |  | | | | | | | | | $ | | 1,100 | | | | |  | | | | | | Wk  Mo  Yr | | | | | |
| **S** | **S** | | **M** | **T** | **W** | **T** | **F** | | | | 37. Hours per shift: | | | | | | | | | **If wage prior to injury varied or included other earnings (tips,** | | | | | | | | | | | | | | | | | | |
| 38. Date left work: | | | | | | | | | | | 39. Time left work:         a.m.  p.m. | | | | | | | | | **room and board, commission, etc.), attach payroll records for the 52 weeks prior to the date of injury.** | | | | | | | | | | | | | | | | | | |
| 40. Return-to-work status:  Not returned  Regular – Date:  Modified – Date: | | | | | | | | | If returned to modified work, is it at regular hours and wages?  Yes  No  **No Lost Time** | | | | | | | | 41. Worker’s scheduled shift on day of injury:  (from)        a.m.  p.m.  (to)        a.m.  p.m. | | | | | | | | | | | | 42. Worker’s regular shift:  (from)        a.m.  p.m.  (to)        a.m.  p.m. | | | | | | | | | |
| 43. Date employer first knew of claim: | | | | | | | | | | | | | 44. Did the injury occur during the course of the job?  Unknown  Yes  No | | | | | | | | | | | | | | | | 45. Employer’s FEIN: | | | | | | | | | |
| 46. | | X | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | 47. If fatal, date of death: | | | | | | |
|  | | *Employer’s Signature Date* | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | |
| 48. | | Print name, title, and phone of signer: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | 49. OSHA log case number: | | | | | | |
| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| LibertyNorthwestBlack  503-239-5800 | **A Guide for Workers Recently Hurt on the Job** |

**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?**

* The insurance company or your employer should be able to answer your questions.
* 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

E-mail: [oiw.questions@state.or.us](mailto:oiw.questions@state.or.us)

**Workers’ Compensation Compliance Section**

Toll-free: 800-452-0288

E-mail: 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).