SDIS - SELF-INSURED EMPLOYERS GROUP
P.O. Box 23879
Tigard, OR 97281-3879
(503) 670-7066 / 1-800-305-1736
Fax (503) 620-6217 • E-mail: wc@sdao.com

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

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ◯ a.m. ◯ p.m.	Regularly scheduled days off:	**DEPT USE:**
Time of injury or illness: ◯ a.m. ◯ p.m.	Time you left work: ◯ a.m. ◯ p.m.	☐ Check here if you are employed by more than one employer:	☐☐☐☐☐☐☐ M T W T F S S	Emp
What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ◯ Left ◯ Right				Ins
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)				Occ
				Nat
				Part
				Ev
				Src
Have you previously injured or sought treatment for this body part? ◯ Yes ◯ No				2src

Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: ◯ M ◯ F
Your mailing address: City State Zip		Home phone:	
E-mail:		Mobile phone:	
SSN (see form 3283):	Dept. & job title:	Work phone:	
Names of Witnesses:	If medical treatment was not with your primary care physician, print name and address of facility:		
Name of your primary care physician:			
Were you hospitalized overnight as an inpatient? ◯ Yes ◯ No	Name and phone number of your health insurance company:		
Were you treated in the emergency room? ◯ Yes ◯ No			

By my signature, I am making 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 requires separate authorization. **I certify, as attested by my signature and under penalty of law, that all information I have given is true and contains no false statements and/or misrepresentations.**

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 wish to file a claim, maintain a copy of this form.

Employer legal business name:	Phone:	FEIN:
Workers shift on day of injury: (from) _____ ◯ a.m. ◯ p.m. (to) _____ ◯ a.m. ◯ p.m.		
Workers weekly wage: Per ◯ Hr. ◯ Day ◯ Wk. ◯ Mo. ◯ Yr. $_____	Give total weekly wage and explain if wage prior to injury varied or included other earnings (tips, room and board, commission, etc.). **Attach 52 weeks of payroll records.**	
Return-to-work status: ◯ Not returned ◯ Regular Date: _____ ◯ Modified Date: _____	If returned to modified work, is it at regular hours and wages? ◯ Yes ◯ No	
Address of principal place of business (not P.O. box): Address City State Zip		Insurance policy no.:
Street address from which worker is/was supervised? Address City State Zip		Nature of business in which worker is/was supervised:
Address where event occurred: Address City State Zip		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ◯ Yes ◯ No		NCCI code:
Were other workers injured? ◯ Yes ◯ No		OSHA 300 log case #:

Date employer knew of claim:	Person claim reported to:	Date worker hired:	If fatal, date of death:
Employer signature:	Name and title (please print):		Date:

(Rev. 1/10)

Location Code: _____

Dept. Code: _____

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

Pain Diagram

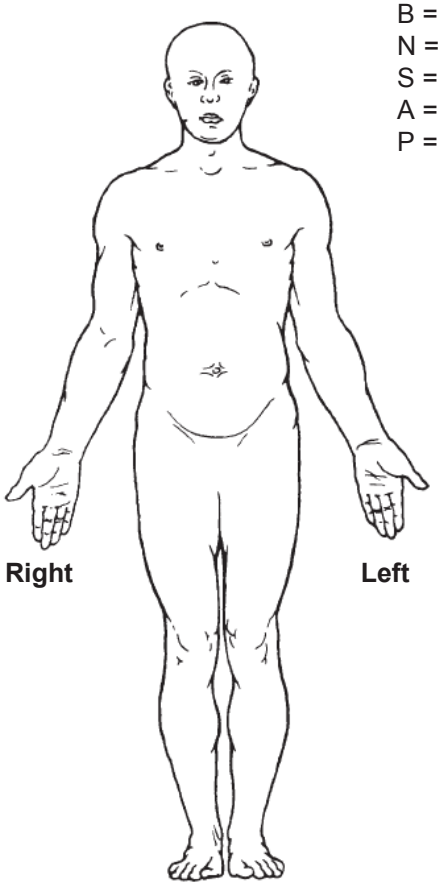
Please complete the Pain Diagram and submit along with the completed Incident Report or Form 801, or both. Retain a copy for your records and mail the completed originals to SDAO, PO Box 23879, Tigard, OR 97281.

Please Note: Completion of the Pain Diagram is voluntary and is not required to apply for workers' compensation benefits.

Name:_____ Employer:_____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

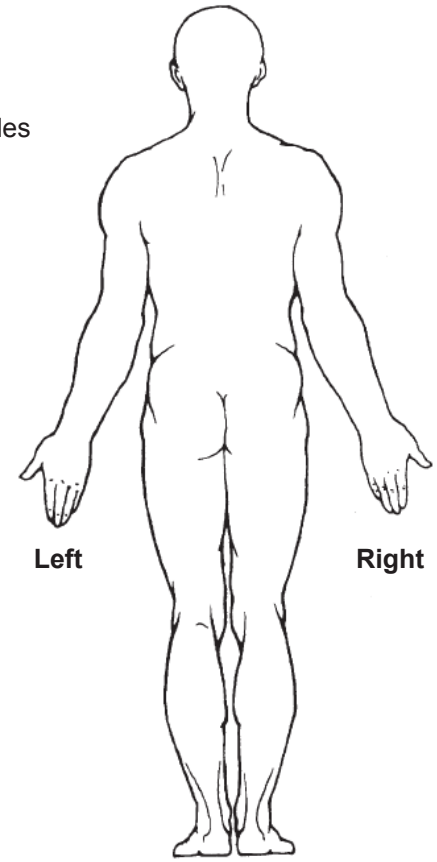
Front



Right **Left**

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Left **Right**

Pain Scale

0 = No Pain *10 = Severe Pain*

Check one: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please use the space below to describe your condition further, if needed:

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: _____

Worker's Signature: _____ Date: _____

SDIS is Administered by
SDAO | PO Box 23879 | Tigard OR 97281
Toll-free: 800-305-1736 | Phone: 503-670-7066 | | Fax: 503-620-6217 | E-mail: wc@sdao.com

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

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

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).

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