NOTICE:
OREGON WORKERS COMPENSATION

This business operates under Oregon Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com
Email: claims@berkleynet.com
Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110
Phone: 877.497.2637
Fax: 866.275.6320

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

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: ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:**
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right				Occ
				Nat
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.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:		Home phone:	
Social Security no. (see Form 3283):	Occupation:	Work phone:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? ☐ Yes ☐ No			
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.

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:
If worker leasing company, list client business name:				Client FEIN:
Address of principal place of business (not P.O. Box):				Insurance policy no.:
Street address from which worker is/was supervised: ZIP:				Nature of business in which worker is/was supervised:
Address where event occurred:				
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No				
Were other workers injured? ☐ Yes ☐ No			OSHA 300 log case no:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:
Employer signature:		Name and title (please print):		Date:

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.

Insert insurer name, address, and phone number

Reporte de Lesión o Enfermedad en el Trabajo

(Report of Job Injury or Illness)

Reclamación de compensación para trabajadores

(Workers' compensation claim)

Trabajador (Worker)

Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte del formulario para el trabajador y entregela a su empleador. **Si usted no tiene la intención de hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea para su firma.** Su empleador le dará una copia. (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 the insurance company, do not sign the signature line.** Your employer will give you a copy.)

Fecha de la lesión o enfermedad (Date of injury or illness):	Fecha que dejó el trabajo (Date you left work):	Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury): ☐ a.m. ☐ p.m.	Días que regularmente no trabaja (Regularly scheduled days off) ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:** Emp
Hora en la que ocurrió la lesión o enfermedad (Time of injury or illness): ☐ a.m. ☐ p.m.	Hora que dejó el trabajo (Time you left work): ☐ a.m. ☐ p.m.	Marque este casillero si usted tiene más de un empleador.(Check here if you are employed by more than one employer): ☐		Ins
				Occ
				Nat
Cuál es su lesión o enfermedad? En qué parte del cuerpo? Qué lado? (Ejemplo: torcedura del pie derecho) What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Izquierdo (Left) ☐ Derecha (Right)				Part
				Ev
Cuál fue la causa? Qué estaba haciendo? Incluya vehículo, maquinaria o herramienta usada. (Ejemplo: caí diez pies mientras subía una escalera de extención cargando una caja de herramientas que pesaba 40 libras) 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)				Src
				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.

Su nombre legal (Your legal name):	Fecha de nacimiento (Birthdate):	Sexo (Gender): M ☐ F ☐
Su dirección postal (Your mailing address):	Teléfono del domicilio (Home phone):	
Número de Seguro Social (opcional) SSN (optional):	Ocupación (Occupation):	Teléfono del trabajo (Work phone):
Nombres de testigos (Names of witnesses):		
Nombre del médico o profesional del cuidado médico (Name of physician or health-care professional):	Si le dieron tratamiento médico fuera del lugar de trabajo, anote el nombre y dirección del lugar (If medical treatment was given away from the worksite, print name and address of facility):	
Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) ☐ Yes ☐ No		
Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) ☐ Yes ☐ No		

Con mi firma: Estoy dando aviso de reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos para liberar los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y el Departamento para Consumidores y Negocios de Oregon. **Aviso:** Expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPPA no es requerida (45 CFR 164.512(I)). Para compartir récords sobre el HIV/AIDS (SIDA), récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.

(**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.)

Firma del trabajador (Worker signature):	Completada por (Completed by) Por favor escriba (please print):	Fecha (Date):

Empleador (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:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. box):		Insurance policy no.:
Street address from which worker is/was supervised: **ZIP**:		Nature of business in which worker is/was supervised:
Address where event occurred:		

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

Were other workers injured? ☐ Yes ☐ No			OSHA 300 log case #:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:
Employer signature:	Name and title (please print):			Date:

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.

801S

440-801S (8/04 tr 11/04/DCBS/WCD/WEB)

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).

440-3283 (01/10/DCBS/WCD/WEB)

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

Una guía para trabajadores lesionados recientemente en el trabajo

¿Cómo presento un reclamo?

- Notifique a su empleador acerca de su lesión o enfermedad en el trabajo lo más pronto posible.
- Pida a su empleador que le dé la **Forma 801, "Reporte de Lesión o Enfermedad en el Trabajo"** y llénela.
- Pregunte a su empleador el nombre de su compañía de seguro de compensación para trabajadores.
- Busque atención médica de un proveedor médico (health care provider) **de su elección** y dígale a su proveedor que se lesionó en el trabajo. Su empleador no puede elegir el proveedor médico por usted.
- Su doctor le pedirá que llene la **Forma 827, "Reporte del Trabajador y Médico para Reclamación de Compensación para Trabajadores."**

¿Cómo obtengo tratamiento médico?

- Usted puede recibir tratamiento médico de un proveedor médico **de su elección,** incluyendo:
  - Enfermeras(os) practicantes autorizadas(os)
  - Quiroprácticos
  - Médicos
  - Naturistas
  - Cirujanos Orales
  - Médicos Osteopáticos
  - Asistentes de doctor
  - Podólogos
  - Otros proveedores médicos
- La compañía de seguros puede inscribirlo en una organización de manejo del cuidado médico (MCO) en cualquier momento. Si la compañía lo hace, usted recibirá más información acerca de las opciones para tratamiento médico.

Si no puedo trabajar, ¿recibiré pagos por salario perdido?

- Es posible que no pueda trabajar debido a su lesión o enfermedad relacionada con el trabajo. Para que usted pueda recibir pago por tiempo fuera del trabajo, su proveedor médico debe enviar una autorización escrita a la aseguradora.
- Generalmente, los tres primeros días calendarios, usted no recibirá pagos por tiempo perdido.
- Es posible que reciba pago por los tres primeros días calendarios, si usted no puede trabajar por 14 días consecutivos, o pasa una noche en el hospital.
- Si su reclamación es negada dentro de los primeros 14 días, no se le pagará por ningún salario perdido.
- Mantenga informado a su empleador acerca del estado de la reclamación y coopere con los esfuerzos que se hagan para que regrese a trabajar en un trabajo modificado o liviano.

¿A quién puedo llamar si tengo preguntas acerca de mi reclamación?

- La compañía de seguros o su empleador puede responder a sus preguntas.
- También puede llamar a los siguientes números:

Ombudsman para Trabajadores Lesionados:
Representate para trabajadores lesionados
Número gratuito: 1-800-927-1271
E-mail: oiw.questions@state.or.us

Línea de información de compensación para trabajadores:
Consultores de Beneficios
Número gratuito: 1-800-452-0288
E-mail: workcomp.questions@state.or.us

- **Los proveedores de cuidado médico pueden tener *limitaciones* en cuanto a la duración de su tratamiento y en cuanto a poder autorizar pago por tiempo fuera del trabajo.** Pregunte a su proveedor médico cuales son las limitaciones que puedan aplicarse.
- **Si su reclamación es negada, es possible que usted tenga que pagar por su tratamiento médico.**

440-3283s (1/07 tr 1/07/DCBS/WCD/WEB)