saif
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

Example

To make a claim for a work-related injury or illness, fill out this form and give to your employer.

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

Employee Will Fill this Part Out

1. Date of injury or illness: 5/6/19
2. Date you left work: 5/6/19
3. Time you began work on day of injury: 7:30 [X] a.m. [ ] p.m.
4. Regularly scheduled days off: Usually Sat + Sun — [ ] M [ ] T [ ] W [ ] T [ ] F [X] S [X] S
5. Time of injury or illness: 3:00 [ ] a.m. [X] p.m.
6. Time you left work: 3:30 [ ] a.m. [X] p.m.
7. Shift on day of injury: Regular Shift Hours 7:30 (from) [X] a.m. [ ] p.m. 4:00 (to) [ ] a.m. [X] p.m.
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) [ ] Left [X] Right — Sprained Right Angle
9. Check here if you have more than one job: [ ]
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)
Was walking on sidewalk, I stepped off side of curb & twisted my Ankle

DEPT USE: Emp / Ins / Occ / Nat / 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: Spongebob Squarepants
12. Language preference: English
13. Birthdate: 12/01/02
14. Gender: [X] M [ ] F
15. Your mailing address: 414 Sweet Pineapple Way City: Newberg State: OR ZIP: 97132
16. Mobile/home phone: (503) 555-1212
17. Occupation: Secretary
18. Work phone: (503) 554-5000
19. Names of witnesses: None
20. Your email address (Optional): SquarepantsS@Newberg.K12.OR.US
21. Name and phone number of health insurance company: Kaiser (503) 813-2000
22. Name and address of health care provider who treated you for the injury or illness you are now reporting: Mr. Krabs, Beaverton Medical Center
23. Have you previously injured this body part? [ ] Yes [X] No
24. Were you hospitalized overnight as an inpatient? [ ] Yes [X] No
25. Were you treated in the emergency room? [X] 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 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(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. **I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.**

27. Worker signature: Spongebob Squarepants
28. Completed by (please print): Spongebob Squarepants
29. Date: 5/6/19

STOP HERE

Employer at time of injury

Complete the rest of this form and give a copy of the form to the worker. If the worker is unavailable, complete with available information. Notify SAIF 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.

SD Fills This Out

30. Employer legal business name: County of Yamhill School District 29J - Newberg School District
31. Phone: (503) 555-4501
32. FEIN: 936001119
33. If worker leasing company, list client business name:
34. Client FEIN:
35. Address of principal place of business (not P.O. Box): 714 E. 6th St., Newberg, OR 97132
36. Insurance policy no.: 60011
37. Street address from which worker is/was supervised: ZIP:
38. Nature of business in which worker is/was supervised: Local gov't - K-12 edu
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: / / If modified work, is it regular hours and wages? [ ] Yes [ ] No

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

50. Employer signature:
51. Name and title (please print):
52. Date: / /

801

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800.922.2689 (toll-free), 503.378.3272, or Oregon Emergency Response, 800.452.0311 (toll-free), on nights and weekends.

Form 801 12 20

*This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division.