INJURED ON THE JOB?

What should I do?

Notify your employer right away and ask for a Form 801 *"Report of Job Injury or Illness."*
You have the right to file a claim if you are injured on the job.

What does my employer have to do?

Your employer must give you the Form 801 *"Report of Job Injury or Illness."* Then, your employer must give notice of your claim to the insurer.

How do I get medical treatment?

Get medical treatment from a doctor or other health care professional of your choice. Your employer cannot choose your health care provider. Some providers have limits on the services they offer, so ask your provider about these limits. Give your employer's name and insurance information listed below to your health care provider.

What if I can't do my job?

Your health care provider may approve time off work. The insurer will tell you if you are eligible for benefits. Your employer may have light-duty work you can do while you recover.

It is important to stay in contact with your employer and your insurer.

If you have questions, you may contact the Ombudsman for Injured Workers at 800-927-1271 or the Workers' Compensation Division at 800-452-0288. You can find the most current information about your employer's workers' compensation insurance at **WorkCompCoverage.wcd.oregon.gov**.

NOTICE OF COMPLIANCE

This employer provides workers' compensation insurance for on-the-job injuries.

Insured policy holder:

Employer:

Insurer:

Policy no.: **Printed:**

440-1188 (7/09/COM)

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division
P.O. Box14480
Salem, OR 97309-0405

Address Service Requested

Oregon Workers' Compensation *REQUIRED POSTING* notice

NOTICE OF COMPLIANCE

Employer:

- Post this notice in each business location in a place where your employees can see it. It is illegal to post this notice when workers' compensation insurance is not in effect.
- Give the insurance and employer information listed at the bottom of the notice to injured workers for their health care provider's billing needs.
- Notify your insurer of a worker's injury within five (5) days of your knowledge of a claim or accident that may result in a compensable injury.
- If you have questions about workers' compensation insurance, call the Workers' Compensation Division at 800-452-0288.
- To order additional posters, Spanish language posters, or to get **Notice of Compliance** information in other languages, call 503-947-7814 or go online to WorkCompPoster.wcd.oregon.gov.
- To look up employer coverage information, go online to WorkCompCoverage.wcd.oregon.gov.

OREGON WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

Employer's First Report of Injury (FROI)

This form, numbered 801, must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, FROI's can be submitted online at www.berkindcomp.com. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records).

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the First Report of Injury. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

Wage Statement

An average weekly wage must be established on any case where it is anticipated that the injured employee might lose work beyond the waiting period of three (3) days. The daily wage and number of days regularly employed is needed to determine the average weekly wage. We may inquire about wages for a similar employee of the same class and grade. Remember computation of wages may include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee if they constitute a financial benefit to the employee and are capable of monetary calculation. If there are weeks with no wages, please explain the reason by coding as follows:
V= Vacation I= Illness L= Lay off P= Personal leave O= Other
If you have any questions, feel free to contact the claim department to assist you.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

Mandatory Poster

The Division of Workers' Compensation poster must be displayed in your personnel office (if there is one) and in prominent places where employees will see it.

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.

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.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep 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:

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.**

Employer signature:	Name and title (please print):	Date:

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.

DCBS | Consumer and 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 Health Care Provider'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
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic physicians
  - Physician assistants
  - Podiatric physicians
  - 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
Email: oiw.questions@oregon.gov

Workers' Compensation Resolution Section
Toll-free: 800-452-0288
Email: workcomp.questions@oregon.gov

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 (1/18/DCBS/WCD/WEB)

DCBS | Consumer and Business Services
Workers' Compensation Division

Una Guía para Trabajadores Lesionados Recientemente en el Trabajo

¿Cómo presento un reclamación?

- Lo más pronto posible notifique de su lesión o enfermedad en el trabajo a su empleador y a un proveedor médico **de su elección**. Su empleador no puede elegir el proveedor médico para usted.
- Pregunte a su empleador el nombre de su compañía de compensación para trabajadores.
- Complete la **Forma 801, "Reporte de Lesión o Enfermedad en el Trabajo"** la forma puede ser obtenida de su empleador. También llene la **Forma 827, "Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores"** esta forma puede ser obtenida de su proveedor médico**.**

¿Cómo obtengo tratamiento médico?

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

¿Existen limitaciones en mi tratamiento médico?

- **Los proveedores de cuidado médico pueden tener *limitaciones* en cuanto a la duración de su tratamiento y en cuanto a la autorización de pago por tiempo fuera del trabajo.** Pregunte a su proveedor médico cuales son las limitaciones que pueden aplicarse.
- **Si su reclamación es negada, es posible que usted tenga que pagar por su 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, usted no recibirá pagos por tiempo perdido por los tres primeros días calendarios.
- Es posible que reciba pago por los tres primeros días calendarios, si usted pierde de trabajar por 14 días consecutivos, o es hospitalizado durante un día incluyendo la noche.
- 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 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 pueden responder a sus preguntas.
- También puede llamar a los siguientes números:

Ombudsman para Trabajadores Lesionados:
Número gratuito: 1-800-927-1271
Email: oiw.questions@oregon.gov

Sección de Resolución de Compensación para Trabajadores:
Número gratuito: 1-800-452-0288
Email: workcomp.questions@oregon.gov

¿**Debo proveer mi número de seguro social en las formas 801 y 827? ¿Para que será usado?** Usted no necesita tener un número de seguro social para recibir beneficios de compensación para trabajadores. Si usted tiene número de seguro social y no lo provee, la División de Compensación para Trabajadores (WCD) del Departamento de Servicios para Consumidores y Negocios lo obtendrá de su empleador, de su aseguradora de compensación para trabajadores, o de otros recursos. WCD puede usar su número de seguro social para intercambio de datos con el Departamento de Empleo, corregir identificación y procesamiento de reclamaciones, cumplimiento, investigación, administración de un programa para trabajadores lesionados, comparación de datos con otras agencias del estado para medir la efectividad de programas de WCD, actividades para prevención de lesiones, y para proveerlo a agencias federales en el programa de Medicare para su uso como está requerido por la ley federal. Las siguientes leyes autorizan a WCD a obtener su número de seguro social: 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).

440-3283s (1/18 tr 1/18/DCBS/WCD/WEB)

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		