



INSTRUCTIONS for Employer's report of occupational injury or disease/illness

Employer: Failure to report a claim to your insurance company within five days after notice or knowledge of the claim may result in untimely payment of time-loss benefits to the worker and a penalty to you or your insurance company. Submit the claim even if the worker is unavailable, unable to provide information, or unable to sign the form. However, the employer's page (Page 1) may be used for OSHA record-keeping even in the absence of a workers' compensation claim. If the worker does not intend to file a claim, do not ask the worker to complete the worker's page (Page 2).

Completion instructions: Type or print in ink. Write clearly. The numbered items below correspond to those on the employer's page of Form 801 (Page 1 of 2) and will help you complete the claim form. Form 801 is also available on the Workers' Compensation Division Web site: www.oregonwcd.org/pubs/formsbyno.html.

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7. Enter the payroll (NCCI) class code under which you report this worker's earnings to your insurer.
13. Examples: truck manufacturing, retail grocery, log hauling, etc.
- 19-22. Several of these questions refer to "clients." If you are a "worker leasing company" or "temporary service provider," as defined in Oregon Revised Statute 656.850(1), the businesses to which you provide workers are your "clients."
30. Check "Yes" if the worker presented a Preferred Worker Eligibility Card to you at the time of hire or you received a "Notice of Premium Exemption" from the Workers' Compensation Division (and the injury occurred on or before the eligibility end date on the card or notice). Attach a copy of the card or notice, if available, to Form 801.
- 38-45. If an agent who represents employees under a collective bargaining agreement asks for a copy of the OSHA incident report, you must provide the information from Form 801, items 38 through 45. Do not release other information except as required or allowed by U.S. or Oregon laws.
45. The OSHA log case number is taken from the OSHA 300 log (if you are subject to OSHA record-keeping).

The employer's page satisfies OSHA Form 301 record-keeping requirements. See OSHA Guidelines (on back of this page).

If you have questions about this form, call the Workers' Compensation Division in Salem, (503) 947-7585, TTY: (503) 947-7993, or toll-free in Oregon: (800) 452-0288.

Si Ud. tiene preguntas relacionadas a este formulario, comuníquese con la División de Compensación para Trabajadores en Salem al número telefónico (503) 947-7585, TTY: (503) 947-7993, o llame gratis en Oregon: 1-800-452-0288.

OSHA record-keeping guidelines

If your business is subject to record-keeping regulations, you are required to record information on OSHA Form 300 and maintain records of occupational injuries or illnesses as described below. Even if your business is exempt from record-keeping, you must have a copy of Oregon Form 801 or equivalent at each establishment for each occupational injury or illness that may result in a compensable claim, pursuant to OAR 437-001-0700(14)(a).

If you are not sure whether your company is subject to OSHA record-keeping requirements or if you have other record-keeping questions, call (503) 947-7030.

NOTE: Every OSHA 300 log entry requires a supporting document. This document may be the Federal OSHA Form 301, State of Oregon Form 801, or an equivalent. Form 801 is also used by workers to file a workers' compensation claim for on-the-job-injuries or occupational illnesses. If the worker decides to file a claim, the worker and employer pages of Form 801 should be completed and signed. Keep photocopies with the 300 log and forward the remaining copies of the Form 801 to your workers' compensation carrier. If a case is recordable under OSHA regulations but is not a claim under workers' compensation laws, complete and retain only the employer page of Form 801 with the 300 log.

An occupational injury or illness is recordable if it is work related and it meets one or more of the following criteria:

- 1) it results in death
- 2) there is loss of consciousness
- 3) there are days away from work, restriction of work or motion, or transfer to another job
- 4) there is medical treatment beyond first aid
- 5) a significant injury or illness is diagnosed by a licensed health-care professional

IMPORTANT: The following is a **complete** list of treatments considered by OSHA to be first aid. If the injured worker receives any of these treatments, and **none** of the (five) criteria listed above apply, **the injury is not recordable.**

- Non-prescription medication at non-prescription strength.
- Tetanus immunizations.
- Cleaning, flushing, or soaking of wounds on the surface of the skin.
- Covering wounds with items such as Band-Aids®, gauze pads, butterfly bandages, or Steri-Strips®.
- Heat or cold therapy.
- Non-rigid support, such as elastic bandages, wraps, non-rigid back belts, etc.
- Temporary immobilization during transport as an accident victim.
- Drilling of fingernail or toenail to relieve pressure, or draining fluid from a blister.
- Eye patches.
- Removal of foreign bodies from the eye by irrigation or with a cotton swab.
- Removal of splinters or foreign material from areas of the body other than the eyes by irrigation, tweezers, cotton swab, or other simple means.
- Use of finger guards.
- Massage therapy.
- Drinking fluids for relief of heat stress.

EMPLOYER's report of occupational injury or disease/illness

NOTE: This form satisfies OSHA Form 301 record-keeping requirements. Complete only this page (Page 1) if the worker is not filing a claim. If the worker completes Page 2 and files a workers' compensation claim, attach a copy of this form and send both to your insurer within five days of notice or knowledge of a claim.

1. Worker's name, mailing address, and phone:		2. Date of birth:	3. Male <input type="checkbox"/> Female <input type="checkbox"/>	4. SSN: - -
		5. Date of hire:	6. State of hire:	7. Payroll class code:
8. Employer's name:		9. Insurance policy no.:		10. Employer FEIN:
11. Immediate supervisor's phone no.: () -	12. Personnel phone number: () -	13. Nature of employer's business:		
14. Department and street address where event occurred:		15. Name and address of medical office (if treated away from work site):		
16. Street address of worker's normal workplace, if different from #14:		17. Name of worker's doctor or other health-care professional:		
18. Employer's business address, if different from #14 or #16:		23. Was worker treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Injury occurred: <input type="checkbox"/> On employer's premises <input type="checkbox"/> On client's premises (if leased/temp worker) <input type="checkbox"/> Off premises <input type="checkbox"/> At unknown location		24. Was worker hospitalized overnight as inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Did injury occur during course of job?.. <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No		
20. Client's name, if employer is leasing co. or temporary agency:		26. Was injury caused by person other than injured worker?.. <input type="checkbox"/> Yes <input type="checkbox"/> No		
		27. Was injury caused by failure of machinery or product? ... <input type="checkbox"/> Yes <input type="checkbox"/> No		
21. Client phone:		22. Client FEIN:		28. Were other workers injured?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
31. Scheduled days off: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> S S M T W T F		32. No. of days worked per week:		29. Is worker an owner or corporate officer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
35. Date left work:		34. Hours per shift:		30. Is worker "premium exempt" (a Preferred Worker)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," attach copy of eligibility card or "Notice of Premium Exemption.")
37. Return-to-work status: <input type="checkbox"/> Not returned <input type="checkbox"/> Regular - Date: <input type="checkbox"/> Modified - Date:		33. Wage & wage period: Per <input type="checkbox"/> Hr <input type="checkbox"/> Day \$ _____ <input type="checkbox"/> Wk. <input type="checkbox"/> Mo <input type="checkbox"/> 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.		
36. Time left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		37. Return-to-work status: If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
EMPLOYER: Do not release data above this line except as required or allowed by U.S. or Oregon laws. Under OAR 437-001-0700(20)(e), data BELOW this line must be released to the worker's collective-bargaining-agreement representative upon request.				
38. Describe how the incident/injury occurred, including the worker's activity, tools, equipment, and materials involved. Describe the injury or illness, including part of body affected and object or substance involved. Example: "Climbing a ladder while carrying roofing materials. Ladder slipped on wet floor and worker fell twenty feet to concrete floor and broke his shoulder."				
39. Worker's shift on day of injury (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		40. Date of injury or illness:	41. Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
42. <u> X </u> <i>Employer's signature</i> _____ <i>Date</i> _____			43. If fatal, date of death:	
44. Print name, title, and phone number of signer:			45. OSHA log case number:	

Attention: Report fatalities or catastrophes to DCBS/OR-OSHA within eight hours of occurrence. Call toll-free in Oregon (800) 922-2689 or (503) 378-3272. Report accidents that result in overnight hospitalization with medical treatment to the DCBS/OR-OSHA local field office within 24 hours of employer notification. At night or on weekends, call Oregon Emergency Response, (800) 452-0311.



INSTRUCTIONS for Worker's report of occupational injury or disease/illness

Worker: Failure to file a claim with your employer within 90 days of injury or within one year of learning you have an occupational illness may result in claim denial. Please read about your rights and responsibilities on the "Notice to Worker" (on back of Form 801) and "*Understanding workers' compensation claims*" (on back of this page).

Completion instructions: Type or print in ink. Write clearly. The numbered items below correspond to those on the worker's page of Form 801 (Page 2 of 2) and will help you complete the claim form. Form 801 is also available on the Workers' Compensation Division Web site: www.oregonwcd.org/pubs/formsbyno.html.

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7. If you were injured, provide the date on which the accident occurred. If you have an occupational illness, enter the date on which you first received medical attention.
10. Describe the type of injury (example: cut leg, broken arm).
11. Enter the number of years of education you have completed (GED is 12.)
12. Identify the body part(s) injured (example: low back, right leg, left shoulder, etc.).
18. Describe the injury or illness as completely as possible.
19. If "Yes," briefly describe the prior injury (example: car accident in 1997, work injury in 1999, etc.).
21. Read this section carefully, as well as "**Important information about your Social Security Number (SSN)**," and "**Caution against making false statements**," on the attached (or on back) "Notice to Worker."

Employer signature block on worker's page

23. FEIN is the Federal Employers Identification Number.
24. Report the earliest of the following:
 - the date you (any supervisor or manager) first knew of a claim
 - the date enough facts existed to lead you to reasonably conclude workers' compensation liability is a possibility.

If you have questions about this form, call the Workers' Compensation Division in Salem, (503) 947-7585, TTY: (503) 947-7993, or toll-free in Oregon: (800) 452-0288.

Si Ud. tiene preguntas relacionadas a este formulario, comuníquese con la División de Compensación para Trabajadores en Salem al número telefónico (503) 947-7585, TTY: (503) 947-7993, o llame gratis en Oregon: 1-800-452-0288.

Understanding workers' compensation claims

A guide for workers recently hurt on the job

You have received this information because you are filing a workers' compensation injury or illness claim (Form 801) with your employer. If you have additional questions, please do one or more of the following:

Contact your employer's workers' compensation insurer to find out information about your claim.

Call the Ombudsman for Injured Workers for help understanding your rights and responsibilities, **(503) 378-3351, toll-free, (800) 927-1271, or TTY (503) 947-7189.**

Call the Workers' Compensation Division (WCD) for general information about benefits, **(503) 947-7585, toll-free (800) 452-0288, or TTY (503) 947-7993.** Visit the WCD Web site: www.oregonwcd.org

Contact the insurer or the Workers' Compensation Division at the phone number above and ask for the brochure "*What happens if I'm hurt on the job?*". The insurer will send this automatically if you are disabled by your injury.

What do I do now?

Tell your doctor that you were hurt on the job. Your doctor will ask you to fill out a Form 827 – "*Worker's and Physician's Report for Workers' Compensation Claims.*" Your doctor will send the Form 827 to the insurer for you.

May I get treatment from any doctor?

Unless the insurer has enrolled you in a managed care organization (MCO), you may treat with any doctor who qualifies as an attending physician under Oregon law. Your attending physician is the doctor who is primarily responsible for your care. Your doctor will tell you if there are any limits to the services he or she can provide.

What are my doctor's responsibilities?

Your doctor is in charge of your medical treatment. Only your doctor can authorize time off work, reduced work hours or duties, or release you to go back to work.

Will my employer's insurer pay my medical bills?

If your claim is accepted, the insurer will pay injury-related medical bills. **Save your receipts** for prescription medications, transportation, and other bills you pay for injury-related treatment and **request reimbursement in writing.** Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

If I can't work, will I receive payments from the insurer for lost wages?

You will receive temporary disability payments if your doctor notifies the insurer that you **cannot work** due to your injuries or releases you to modified work that results in a loss of wages. However, Oregon law requires a three-day waiting period for these benefits. You won't be paid for the first three calendar days of lost wages unless your doctor does not release you to do any type of work for at least 14 days from the time you left work or if you were an inpatient in a hospital during your first 14 days of total disability.

If you have additional employer(s), you may be eligible to receive supplemental disability payments. You must notify the insurer about your other job(s) **and** provide proof of wages paid on the other job(s), i.e., check stubs or payroll records, **within 30 days of the insurer's receipt of your initial claim,** or you will lose your eligibility to receive supplemental disability benefits.

What can I do to make sure I receive benefits to which I am entitled?

- Find out the legal business name of your employer and the name of its workers' compensation insurer. If you have a problem getting this information, call the Workers' Compensation Division Employer Index, **(503) 947-7814.**
- Keep all medical appointments and follow your doctor's instructions regarding your medical care.
- Read and keep copies of all letters and forms you receive regarding your claim.
- Keep track of phone calls, including with whom you speak, subject matter, and dates.
- Observe all deadlines. Do not be late to submit information or to file appeals.
- Contact your employer immediately when your doctor releases you for work.
- Contact the insurer if you have questions.
- If you have questions about your claim that are not resolved by your employer or insurer, contact the Ombudsman for Injured Workers or the Workers' Compensation Division.

WORKER's report of occupational injury or disease/illness claim

1. Worker's language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (please specify):			
2. Worker's legal name (first, m.i., last):	3. Date of birth:	4. Male <input type="checkbox"/> Female <input type="checkbox"/>	5. Social Security number (See attached "Notice to Worker"): - -
6. Worker's street, mailing, and e-mail addresses:	7. Date of injury/illness:	8. Time of injury/illness:	9. Last date worked:
	10. Nature of injury/illness (strain, cut, bruise, etc.):		11. Education: Grade completed (0-20):
Home phone: () -	12. Body part(s) affected: <input type="checkbox"/> Left <input type="checkbox"/> Right		
Work phone: () -			
13. Employer's name, street address, and phone no.:	14. Name of medical provider who first treated injury/illness: Phone: () -		
	15. Name of regular doctor: Phone: () -		
16. Occupation (job title):	17. Name, phone, and ID or group no. of personal health insurer:		
18. Describe the injury or illness fully (how and where it occurred):			

Witnesses (if any):

19. Has body part been injured before? (If "Yes," explain.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Dept. use Emp no
20. Check here if you have more than one employer: <input type="checkbox"/> See attached <i>Understanding workers' compensation claims</i> under "If I can't work, will I receive payments from the insurer for lost wages?" to find out if you are eligible for additional benefits.	Ins no
<p>21. By my signature: I am giving NOTICE OF CLAIM for workers' compensation medical or disability benefits. I certify that the above information is true to the best of my knowledge and belief. I authorize medical providers and other custodians of the claim record to release medical records relevant to the injury or disease claimed on this 801 to the workers' compensation insurance company and the Oregon Department of Consumer and Business Services. Medical information relevant to the claim includes a history of the complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. This form does not authorize release of the following information:</p> <ul style="list-style-type: none"> • Participation in federally funded treatment programs for drug and alcohol abuse under Fed. Regulation 42, CFR (2). • HIV-related information unless the claimed condition is HIV or AIDS or when such information is relevant to the claimed condition(s). <p>I authorize the use of my SSN as described in Paragraph 2 of the "Notice to Worker" on the back of this form. (If you do not authorize the use of your SSN as described in Paragraph 2, check here <input type="checkbox"/>.)</p>	Occ Nature Part Event Source Assoc Object

Worker: Sign form and give it to your employer on the day you sign it. Your employer will give you a copy. X
Worker's signature Today's date

Employer: Provide information below, sign form, and give the worker a copy immediately. Send a copy to the insurer, along with Page 1 or other injury/illness report, within 5 days of Notice of Claim. Retain a copy for your records.

22. Employer's legal name:	25. Name, title, and phone number of signer: <u> X </u> Signature of employer representative Today's date
23. Employer's FEIN:	
24. Date employer first knew of claim:	

Notice to Worker

Important information about your Social Security Number (SSN)

1. You must provide your SSN. The Workers' Compensation Division (WCD) of the Department of Consumer and Business Services (DCBS) has authority to request your SSN under the *Privacy Act of 1974*, 5 USC & 552a (West 1977), Section 7(a)(2)(B). Authority under state law is provided in Oregon Revised Statute 656.265 and under Administrative Order WCB 4-1967 codified at OAR 436 Division 060. DCBS will use your SSN to carry out its duties under ORS Chapter 656, including compliance, research, claims processing, and injured-worker-program administration. The workers' compensation insurer will use your SSN to obtain records related to your claim.
2. DCBS requests your voluntary authorization to give your SSN to other government agencies to use for their statutory duties, including, but not limited to, planning, research, child-support enforcement, employment assistance, benefit coordination, child-labor-law enforcement, risk management, hazard identification, rate setting, and training programs. If you do not authorize this use, please check the box by your signature on the front of Form 801. Checking this box will not interfere with the processing of your workers' compensation claim.

Caution against making false statements

3. The punishment for anyone who is convicted for knowingly making any false statement or representation for the purpose of obtaining any benefit or payment, is imprisonment for not more than one year, a fine of not more than \$1,000, or both, under ORS 656.990(1).

Form 801 is your receipt that you gave notice of a claim. Keep it as your record.

4. Your employer is required to submit your claim to its insurer within five days. The insurer must notify you of its acceptance or denial within 60 days after the date your employer knows of your claim. If your employer is self-insured, the acceptance or denial notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. If your claim is denied, the reason for the denial and your rights will be explained.

If you have questions about your claim that are not resolved by your employer or insurer, you may contact; (Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers' Compensation Division
(División de Compensación para Trabajadores)
350 Winter Street NE, Rm. 27, Salem, OR 97301-3879 **OR**
Call Salem: (503) 947-7585, TTY: (503) 947-7993,
or toll-free in Oregon: (800) 452-0288

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
(503) 378-3351, TTY: (503) 947-7189,
or toll-free: (800) 927-1271