

Injury / Accident Report

This report must be completed within 24 hours of an accident involving an injury to students, employees or visitors. Send completed reports to Tracy Suckow at the District Office. Attach additional pages if necessary.

Sisters School District

"Home of the Outlaws"

1.	Who was injured? Student	mployee Visitor										
	Name of Injured Person:											
	Home Address:											
	Phone Number:											
	Employee Job Title or Occupation:											
	Sex: Male Female:											
2.	When and Where did this happen?											
	Date of Injury:	Time Injury Occurred:										
	Date Reported:	Time Reported:										
Name of Parent/Guardian/Spouse or significant other notified: Who made the notification and when?												
	Did injury occur on District property	? Yes No										

Describe the exact location where the injury occurred:

3. HOW DID THIS HAPPEN? What was the injured person doing at the time of injury? Describe the events immediately preceding the injury. Identify any employees involved in the accident and any tools, machinery, equipment, or vehicles involved. Attach photos if applicable.

4. WHAT INJURIES RESULTED? Type of injuries and body part(s) injured. Example: "sprained arm."



5. DID ANYONE SEE THE INJURY HAPPEN? Name(s) and phone numbers of witness(es) if any. (Attach statement of each witness).

6.	DID ANYONE ELSE CAUSE THIS INJURY? Other person(s) that caused or contributed to the injury, if any. Name: Home Address:
	Phone Number: Was an arrest made? Yes No
7.	WAS MEDICAL TREATMENT NEEDED?
	Was first aid administered? Yes No
	Name: Did injured party go to a hospital/urgent care/clinic? Yes No
	Describe medical treatment received:
	Did a supervisor accompany injured person? Yes No
	Physician's Name:
	Name of hospital/urgent care/clinic: Phone Number:
	Injured Person's Signature Date

Supervisor's Signature

saif
D0 High St. SE Salem, OR 97312

For SAIF Cu	ustomer 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

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.

1. Date of injury or illness:	1	1	2. Date you left work:	ı /	1			. Time you began yon have a second se	work					a.m.	4. Reg days o	ularly scheduled		DEPT USE:
5. Time of injury		Ta.m.	6. Time yo	u		a.m.	7	. Shift on		~		(from)	a.m.	p.m.			٦nl	Emp
or illness:		p.m.	left work:				d	ay of injury:				(to)	a.m.	p.m.	MT	WTFS	s	Ins
8. What is your illnes	ss or in	jury? What pa	rt of the body	? Which	side? (Ex	ample: spi	raine	d right foot)		Left	Right					ck here if you h han one job:	ave	Occ
10. What caused it?	What y	vere vou doing	g? Include ve	hicle, ma	chinery, o	or tool use	ed. (E	xample: Fell 10 fe	et wh	en climbing a	an exten	sion lade	ler carrying	a 40-pour			als)	Nat
			5				.u. (.2							, to bom				Part
																	- [	Ev
																		Src
																		2src
Information AB	OVE	this line: da	te of death,	if death	occurr	ed; and	Oreg	gon OSHA case	log	number mu	ist be r	eleased	to an auth	orized v	vorker	representativ	e upor	n request.
11. Your legal name:							12.1	anguage preferenc	ce:					13. B	irthdate:	,	14. Ge	the second s
15. Your mailing add	lress:							Ci	ity:			State	ZIP		1	/ 16. Mobile/ho	M me pho	
17. Occupation:					1	<u></u>				100 B			and and			18. Work phor	ne:	
19. Names of witness	ses:								2	0. Your emai	1 address	s (Option	al):					
21. Name and phone	numbe	er of health ins	surance comp	any:						2. Name and re now report		ofhealt	n care provid	er who tr	eated yo	u for the injury of	or illnes	ss you
23. Have you previou	usly inj	ured this body	part?			Yes		No										
24. Were you hospita	alized o	vernight as an	inpatient?			Yes		No										
25. Were you treated	in the	emergency roo	om?			Yes		No										
26. By my signature release relevant medic of prior treatment for t records protected by st	cal record the same	ds to the worke e conditions or	ers' compensa of injuries to	tion insure the same a	r, self-insu rea of the	ared emplo body. A HI	oyer, c IPAA	laim administrator, a authorization is not	and th t requir	e Oregon Dep red (45 CFR 1	oartment 64.512(I	of Consu )). Releas	mer and Busi e of HIV/AII	ness Servi OS records	ces. Noti , certain	ce: Relevant mee drug and alcohol	lical rec treatme	cords include record ent records, and othe
27. Worker signature:								28. Completed I (please print):	by							29. D	ate: /	1
						Fm	m	loyer at t	tim	a of in	nim	-17						
Complete the r Notify SAIF w	rest c vithir	of this for five days	m and gi s of knov	ve a co vledge	py of of the	the for	m t	o the worker	r. If	the work	er is	unava	ilable, co e a clain	omplet n, main	e with ntain	h available a copy of t	info his fo	rmation. orm.
30. Employer legal business name:											31. P	hone:			32.	FEIN:		
33. If worker leasing list client business na		any,													34. FE	Client IN:		
35. Address of principal place 36. Insurance of business (not P.O. Box): 90icy no.:																		
37. Street address fro worker is/was superv		ch								-		ZIP:				Nature of busin ervised:	ess in w	which worker is/wa
39. Address where event occurred:																		
40. Was injury cause	ed by fa	ilure of a mac	hine or produ	ict, or by	a person o	other than	the in	njured worker?			Ľ	Yes	No		41.	Class code:		
42. Were other work	ters inju	ured?	Yes	No		id injury c cope of jol		during course	C	Unknown	C	Yes	No		44.	OSHA 300 log	case no	0:
45. Date employer knew of claim:				46. Worke weekly w					47. hire	Date worker d:					8. If fata f death	l, date		
49. Return-to-work s	status:	Not returned		۵	Regu Date:	lar	1	/	] Mo Dat	dified e: /	1		If modifie	ed work, i	s it regu	lar hours and wa	ages?	Yes No
By my signature, I ac care provider. If I do,						npensation	insura	ance company within	n five c	lays of knowle	dge of th	e claim. I	understand	l may not	restrict t	he worker's choi	ice of or	r access to a health
50 Employer						51 Nam		title								52 5	latar	



signature:

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

(please print):

### A guide for workers recently hurt on the job

The following information is provided by SAIF at the request of the Workers' Compensation Division

### 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, "Workers' and Health Care Provider's Report for Workers' Compensation Claim," 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.

400 High St SE Salem, OR 97312

- 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?

- SAIF or your employer should be able to answer your questions. Call SAIF at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

### Ombuds Office for Oregon Workers: (an advocate for injured workers)

Toll-free: 800.927.1271

Email: oow.questions@dcbs.oregon.gov

### Workers' Compensation Resolution Section

Toll-free: 800.452.0288

Email: workcomp.questions@dcbs.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, 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 the following: 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).

Form 3283\* | SAIF 01.23 (440-3283, 07/22/DCBS/WCD/WEB) for distribution with Form 801. \*This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division