

"sprained arm."

# Sisters School District "Home of the Outlaws"

### 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.

ice.	. Attach additional pages if necessary.
1.	Who was injured? Student Employee 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:



# Sisters School District "Home of the Outlaws"

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 Name: Physician's Name: Name of hospital/urgent care/clinic: Phone Number:
	Injured Person's Signature Date
	Supervisor's Signature Date



		CLAIM NO.
For SAIF	Customer Use	SUBJECT DATE
Area		CLASS
Dept.		DEFAULT DATE
Shift	CC	EMPLOYER'S ACCOUNT NO.
		first and the second se

Email: <u>saif801@saif.com</u>
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.

S. Time of Figings   man.   S. Time you.   man.   S. Time you.   man.	or illness: / /	2. Date		1		3. Time you began on day of injury:	work					a.m.	4. Reg	ularly scheduled	DEPT USE:
to lines or injury? What is your illness or injury? What part of the body? Which side? (Example: speaked right foot)   Left   Night		( T				, , ,		-		(from)	<u> </u>	p.m.			Emp
B. What is your illures or injury? What part of the body? Which sadd? (Example: systamed right foot)   Left   Right   Section   Rock there if you have ment that an age with the control of the body? Which sadd? (Example: partial right foot)   Left   Right   Section   Rock there if you have ment that are given being here.   Nat   Part   Ev   Sec   Rock there if you have been distributed at the part   Rock the section   Rock the s		left wor	•	l I	=					,	=	=	M T	W T F S S	Ins
Next caused at? 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   28 rc	8. What is your illness or injury? W	••	ody? Which	side? (Exan		ned right foot)		Left	Right						Осс
Part   Ev   Src   2src   2src   1.1 Nover legal name:   12. Language preference:   12. Language preference:   13. Birthdate:   16. Model-bomme phone:   15. Your emailing address:   16. Model-bomme phone:   16. Model-bomme phone:   16. Model-bomme phone:   17. Occupations:   18. Work phone:   18. W	10 What caused it? What were yo	u doing? Include	vehicle mad	chinery or	tool used	(Example: Fell 10	feet wh	en climb	oing an exte	ension ladd	er carrying	a 40-nour	_		Nat
Src     2src     2s	,												Part		
Paper   Pape	 												Ev		
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. You're legal name:													Src		
11. Your legal name:     12. Language preference:     13. Birtholar:     14. Gender:       15. Your mailing address:       16. Mobile-home phone:       16. Mobile-home phone:	2src													2src	
15. Your mailing address:   City:   State:   ZIP:   16. Mobile-home phone:	Information ABOVE this lin	e: date of dea	th, if death	occurred	d; and O	regon OSHA cas	se log	numbe	r must be	released	to an au	thorized	worker	representative upo	on request.
15. Your mailing address:   City:   State: ZIP:   16. Mobile/home phone:   17. Occupation:   18. Work phone:   18. Wor	11. Your legal name:				12	2. Language prefere	nce:					13. B	irthdate:		
19. Names of witnesses:    20. Your email address (Optional):   22. Name and address of health insurance company:   23. Have you previously injured this body part?   Yes   No     24. Were you hospitulized overnight as an impatient?   Yes   No     25. Were you treated in the emergency room?   Yes   No     26. By my signature, I am making a claim for worker's compensation issue, referenced include records to the search of prior treatment for the same conditions or of injuries to the same conditions or of injuries or the same conditions or of injuries to the same conditions or of injuries to the same conditions or of injuries or the same conditions or of injuries to the same conditions or of injuries or the same conditions or of injuries or the same conditions or of injuries or the same conditions or of injuries. I worker of injuries or the same conditions or of injuries. I same conditions or of injuries or the same conditions or of	15 Your mailing address:						City:	-	-	State	71	p.	/		
20. Your email address (Optional):  21. Name and phone number of health insurance company:  22. Name and address of health care provider who treated you for the injury or illness you are now reporting:  23. Have you previously injured this body part?  24. Were you treated in the emergency room?  25. Were you treated in the emergency room?  26. By my signature, I, am making a claim for worker's compensation herefult. The above information is true to the best of my knowledge and belief. I sutherize health care provider and other cautodians of claim records to the care are clear the care continuous or of injuries to the same area of the body. A HIPAA sutherization is not required (45 CPR, 164.5)(20), Release of HIV/AIDS records, certain drug, and alcohol treatment records protected by state and foderal 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 656.235.  27. Worker  28. Completed by (please print):  29. Date:  (please print):  29. Date:  (please print):  29. Date:  30. Employer legal business name:  31. Phone:  32. FEIN.  33. Phone:  33. If worker leasing company,  134. Cliest results 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.  30. Employer legal business name:  31. Phone:  32. FEIN.  33. Phone:  34. Cliest results of this form which worker is was supervised.  39. Address of principal place of business name:  31. Phone:  32. FEIN.  33. Name of business in which worker is was supervised.  40. Was injury caused by failure of a machine or product, or by a person other than the injured worker?  41. Date employer  42. Were other workers injured?  43. Date employer  44. Were other workers injured?  45. Date employer  46. Worker's was supervised.  47. Date workers in this supervised.  48. Palaware of bus	15. Your manning address.						city.			State.	21	•		ro. Woone nome pr	ione.
21. Name and phone number of health insurance company.  22. Name and address of health care provider who treated you for the injury or illness you are how reporting:  23. Have you previously injured this body part?  24. Were you hospitalized overnight as an inpatient?  25. Were you treated in the emergency room?  26. By my signature, I am making a claim for worker's compensation herefits. 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 refracted records to be described incored from the conditions or of injurities to the same area of the body. A HIPAA subtorization is not required (45 CFR 164-13(10)). Release of HIV/AIDS records, certain drug and alcebol treatment records, and other custodians of claim records and officered by state and foderal 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 65-60-325.  27. Worker  28. Completed by (please print):  29. Date:  29. Date:  29. Date:  29. Date:  29. Date:  29. Date:  30. Employer legal by (please print):  29. Date:  30. Employer legal by (please print):  31. Phone:  32. FEIN:  33. If worker leasing company,  13. If worker leasing company,  13. If worker leasing company,  14. Class code:  40. Was injury caused by failure of a machine or product, or by a person other than the injured worker?  40. Was injury caused by failure of a machine or product, or by a person other than the injured worker?  41. Date worker is was supervised:  42. Date employer  43. Date employer  44. Obsterer's  45. Date employer  46. Worker's  46. Worker's  47. Date worker  48. If fatal, date  49. Return-to-works is aluss: Not returned	17. Occupation:		,	,										18. Work phone:	
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24. Were you hospitalized overnight as an inpatient?   Yes   No    25. Were you treated in the emergency room?   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 retease relevant medical records in the worker's compensation insurer, self-insurance displayer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records in the conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 16-13(2)). Release of HIV/AIDS records, certain day and alcohol records in opticity of provider of my choice subject to certain restrictions under ORS 65-240 and ORS 65-235.  27. Worker's ignature.  28. Completed by (please print):  29. Date:   29. D								u for the injury or illn	ess you						
25. Were you treated in the emergency room?   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 receive servent modical records to two workers' compensation is insure, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records to 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(II)). Release of HIV/AIDS records, certain drug and alcohol reatment 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 656.209 and ORS 656.315.  27. Worker's signature.  28. Completed the worker is unavailable, complete with available information.  Notify SAIF within five days of knowledge of the form to the worker of the worker does not wish to file a claim, maintain a copy of this form.  30. Employer legal business name:  31. Phone:  32. FEIN:  33. Howere classing company, ist clearly business name:  33. Address of principal place of business (not P.O. Bos):  34. Client FEIN:  35. Address of principal place of business (not P.O. Bos):  36. Insurance policy no:  37. Street address from which worker is/was apprevised:  38. Nature of business in which worker is/was apprevised:  49. Were other workers injured?   Yes   No   41. Class code:  44. Were other workers injured?   Yes   No   44. OSHA 300 log case no:  45. Date employer knew of claim:  46. Was injury caused by failure of a machine or product, or by a person other than the injured worker?   47. Date worker hired:  47. Date worker injured?   Yes   No   44. OSHA 300 log case no:  48. Employer   Yes   No   44. OSHA 300 log case no:  49. Return-to-work status: Not ret	23. Have you previously injured th	is body part?			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 recease relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notices Relevant medical records in clude records of prior treatment for the same or and time to the same or and the body. A HIPAA authorization is not required (45 CFR 164 SEQ10). Release of HIV/ADDS records, certain drag 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 656.269 and ORS 656.325.  27. Worker signature:    28. Completed by (please print)   29. Date:	24. Were you hospitalized overnight	nt as an inpatient	)		Yes	No									
release relevant medical records to the workors' compensation insurer, self-insured comployer, 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 666.269 and ORS 665.255.  27. Worker signature.  28. Completed by (please print):  29. Date:	25. Were you treated in the emerge	ncy room?			Yes	No									
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.  30. Employer legal business name:  31. Phone:  32. FEIN:  33. If worker leasing company, is the claim of the unique of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.  33. If worker leasing company, is the claim of the unique of the claim. Even if the worker is unavailable, complete with available information. Notify SAIF within five days of knowledge of the claim. I understand I may not restrict the worker is/was unavailable, complete with available information. Notify SAIF within five days of knowledge of the claim. I understand I may not restrict the worker is/was unavailable, complete with available information. Notify SAIF within five days of knowledge of the claim. I understand I may not restrict the worker's singular.	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(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.														
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.  30. Employer legal business name:  31. Phone:  32. FEIN:  33. If worker leasing company, list client business name:  35. Address of principal place of business from thich worker loss supervised:  36. Insurance policy no.:  37. Street address from which worker solves supervised:  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?  42. Were other workers injured?  43. Did injury occur during course   Unknown   Yes   No   41. Class code:  44. OSHA 300 log case no:  45. Date employer  45. Date employer  46. Worker's   weekly wage: \$   hired:   hired:   hired:   worker   hired:   ds. If fatal, date   details. It understand I may not restrict the worker's 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 1 do, it ould result in civil penalties under OKS 655.260.  50. Employer  51. Name and title (please print):  52. Date:	27. Worker signature:													29. Date:	1
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.  30. Employer legal business name:  31. Phone:  32. FEIN:  33. Flow this form and give a copy of the form to the worker does not wish to file a claim, maintain a copy of this form.  34. Client FEIN:  35. Address of principal place of business (not P.O. Box):  37. Street address from which worker is/was supervised:  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?  40. Was injury caused by failure of a machine or product, or by a person other than the injured worker?  42. Were other workers injured?  45. Date employer week of claim:  46. Worker's weekly wage: \$  47. Date worker indied:  49. Return-to-work status: Not returned   Regular Date:   Modified Date:   Modified Worker, is it regular hours and wages?   Yes   No    By my signature.   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 evil penalties under ORS 653-206.  51. Name and title (please print):  52. Date:   Modified Date:   Mo					T.			• • • •	c : . : .						,
business name:  33. If worker leasing company, list client business name:  35. Address of principal place of business (not P.O. Box):  37. Street address from which worker is/was supervised:  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?  42. Were other workers injured?  43. Did injury occur during course and soope of job?  44. OSHA 300 log case no:  45. Date employer knew of claim:  46. Worker's weekly wage: \$  47. Date worker hired:  49. Return-to-work status: Not returned   Regular /   Modified /   If modified work, is it regular hours and wages?   Yes   No    49. Return-to-work status: Not returned   Patter	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.														
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45. Date employer knew of claim:  46. Worker's weekly wage: \$ 47. Date worker hired: 47. Date worker hired: 48. If fatal, date of death  49. Return-to-work status: Not returned	40. Was injury caused by failure of	a machine or pr	oduct, or by	a person oth	ner than th	e injured worker?				Yes	No		41.	Class code:	
knew of claim:   weekly wage: \$   hired:   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:   / /	42. Were other workers injured?	Yes	No					Unkno	wn	Yes	No		44.	OSHA 300 log case	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:									orker					l, date	
50. Employer signature:  51. Name and title (please print):  52. Date:															
50. Employer signature:  51. Name and title (please print):  52. Date:	By my signature, I acknowledge I am care provider. If I do. it could result	responsible for no	tifying my wo		ensation ins	surance company with		-	nowledge of	the claim. I	understand	I may not	restrict t	he worker's choice of	or access to a health
	50. Employer			5	1. Name a	and title									1 1
A B B B B B B B B B B B B B B B B B B B	OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition,														

#### 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.
- 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 modifiedor 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).