

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

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness:	2. Date you left work:	3. Time you began work on day of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	4. Regularly scheduled days off: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S	DEPT USE: Emp Ins Occ Nat Part Ev Src 2src
5. Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	6. Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	7. 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.		
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) <input type="checkbox"/> Left <input type="checkbox"/> Right			9. Check here if you have more than one job: <input type="checkbox"/>	
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)				

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:	12. Worker's language preference other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):	13. Birthdate:	14. Gender: <input type="checkbox"/> M <input type="checkbox"/> F
15. Your mailing address, city, state and zip:		16. Home phone:	
17. Social Security no. (see back*):	18. Occupation:	19. Work phone:	
20. Names of witnesses:			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. Were you hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>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.</p>			
27. Worker signature:	28. Completed by (please print):	29. Date:	

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation 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: Southern Oregon Child and Family Council	31. Phone: 541-734-5150 ext1025	32. FEIN: 93-0564896
33. If worker leasing company, list client business name:	34. Client FEIN:	
35. Address of principal place of business (not P.O. Box): 1001 Beall Lane, Central Point, OR 97502	36. Insurance policy no.: 775973	
37. Street address from which worker is/was supervised: _____ ZIP: _____	38. Nature of business in 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	41. Class code:	
42. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Regular Date: <input type="checkbox"/> Modified Date: <input type="checkbox"/>	50. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
51. Employer signature:	52. Name and title (please print): Raco Verhaaren, Human Resources Manager	53. Date: