saifcorporation
400 High Street, S.E., Salem, OR 97312-1801

For SAIF Customer Use
Area _____ _____ _____
Dept. _____
Shift _____ CC _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

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. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ ☐ ☐ ☐ ☐ ☐ ☐ M T W T F S S
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right		9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)			
11. Name of witnesses:		12. Have you previously injured this body part? ☐ Yes ☐ No	
13. Your legal name:		14. Birthdate:	15. Gender: ☐ M ☐ F
16. Mailing address, city, state and zip:			17. Home phone:
18. SSN (See #25 below):	19. Occupation:		20. Work phone:
21. Name of physician or health-care professional:		22. If medical treatment was given away from the worksite, print name and address of facility:	
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
24. Were you treated in the emergency room? ☐ Yes ☐ No			
25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers 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(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.			
26. Worker signature:	27. Completed by (please print):		28. 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.

29. Employer legal business name: JACKSON COUNTY SCHOOL DISTRICT # 6		30. Phone: (541) 494-6212	31. FEIN: 93-6000508
32. If worker leasing company, list client business name:			33. Client FEIN:
34. Address of principal place of business (not P.O. box): 300 ASH STREET, CENTRAL POINT, OREGON 97502			35. Insurance policy no.: 930280
36. Street address from which worker is/was supervised: ZIP:			37. Nature of business in which worker is/was supervised: K-12 EDUCATION
38. Street address, city, and state where event occurred:			
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No			40. Class code:
41. Were other workers injured? ☐ Yes ☐ No	42. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No		43. OSHA 300 log case #:
44. Date employer knew of claim:	45. Worker's weekly wage: $	46. Date worker hired:	47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:			49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature:	51. Name, title, and phone (please print): TAMMY TAYLOR (PAYROLL CLERK)		52. Date:

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OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

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