

# Report of Job Injury or Illness

2009 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 the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regularly scheduled days off:	<b>DEPT USE:</b>
Time of injury or illness:	Time you left work:	Check here if you are employed by more than one employer:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M T W T F S S	Emp
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
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)					Ins
					Occ
					Nat
					Part
					Ev
					Src
					2src

**Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.**

Your legal name:	Birthdate:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Your mailing address:	Home phone:	
SSN (optional):	Occupation:	Work phone:
Names of witnesses:		
Name of physician or health-care professional:	If medical treatment was given away from the worksite, print name and address of facility:	
Were you hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p><b>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:</b> 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 require separate authorization.</p>		
Worker signature:	Completed by (please print):	Date:

## Employer

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company 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.

Employer legal business name: <b>Willamette University</b>	Phone: <b>503.370.6210</b>	FEIN: <b>93-0386972</b>
If worker leasing company, list client business name: <b>Not Applicable</b>	Client FEIN:	
Address of principal place of business (not P.O. box): <b>900 State Street, Salem, OR 97301</b>	Insurance policy no.: <b>024 WC09 0045</b>	
Street address from which worker is/was supervised: <b>Same as Above</b>	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:	<b>Higher Education</b>	
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		
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	OSHA 300 log case #:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: \$
Date worker hired:	If fatal, date of death:	
Employer signature:	Name and title (please print):	Date:

**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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