Injured Worker Packet

Process & Procedure Guide

What to do when an employee is injured on-the-job

If the Employee Does Not Seek Medical Attention*	Employee: complete ONLY the Injury/Illness/Incident Report Form (below) and send to Human Resources. Do not complete the 801 form.

**If the employee is not sure if they should seek medical attention, they can call Rapid Care at (855) 959-2741. Rapid Care is available 24/7 and can recommend immediate care instructions, assist with making a doctor's appointment, help complete the 801 form, and provide first prescription fills.*

If the Employee Does Seek Medical Attention	Employee**: complete the Injury/Illness/Incident Report Form (below) *and* the 801 form (below) and send both to Human Resources.
	Employee: review the guide to workers compensation claims (below).
	Supervisor: Immediately notify HR if the employee is hospitalized.

***If the injury is serious and completing forms prior to seeking medical treatment is not reasonable, the employee's supervisor should complete what they can and turn in as outlined above.*

While Employee Seeks Medical Attention	Employee: discuss physical requirements of your normal job with your medical provider and ask them to complete the Return-to-Work Status form (below). Return the form to your supervisor.
	Employee: continue to bring any updated Return-to-Work Status release forms to your supervisor after each visit to your medical provider.
	Human Resources: start the claims process with SAIF
	Supervisor: forward all Return-to-Work Status forms to Human Resources.
	Supervisor: prepare modified duty offer and make any needed arrangements for the modified duty.

If Employee Accepts Modified Duty After Seeking Medical Attention	Employee: continue to bring any updated Return-to-Work Status release forms to your supervisor after each visit to your medical provider.
	Supervisor: continue to forward all Return-to-Work Status forms to HR.
	Supervisor: continue to revise modified work plan, as needs of the employee change, and keep Human Resources updated.

If Employee Cannot Work Due to Injury	Employee: provide documentation from healthcare provider to Supervisor or Human Resources authorizing absence from regular AND modified duty.
	Human Resources: provide employee with information regarding leave.
	Employee: continue to communicate with supervisor while on leave.

Injured Worker Packet

Guide to Workers Compensation

How to file a claim

- If the employee believes they were injured at work or suffer from an illness because of your job, they should tell their supervisor or HR as soon as possible.
- The employee should then complete the "worker" portion of the form 801, "Report of Job Injury or Illness," and give it to their supervisor.
- HR will complete the employer portion of the 801 form and send it to SAIF insurance company.
- The employee can seek medical treatment from a health care provider of their choice and tell the provider they were injured on the job. *Remember: the City cannot choose the health care provider.*

How to get medical treatment

Employees may receive treatment from a health care provider of their choice on the initial claim, including:

- Authorized nurse practitioner
- Chiropractic physician
- Medical doctor
- Naturopathic physician
- Oral surgeon
- Osteopathic physician
- Physician assistant
- Podiatric physician
- Other health care providers
- The health care provider will bill SAIF. If the claim is accepted, SAIF will pay for medical treatment related to the work injury, with some limitations. If the claim is denied, or SAIF determines the services are not related to the work injury, the employee may have to pay for their medical treatment.

How to find the status of a claim

SAIF must accept or deny the claim within 60 days of the day The City has notice or knowledge of the claim. This is referred to as the interim period.

- If the claim is accepted, SAIF will send the employee a "Notice of Acceptance" that lists the specific medical conditions accepted.
- If the employee believes SAIF has not listed all the conditions caused by the injury, they must request, in writing, that SAIF add the missing conditions to the notice. If they believe that the notice is incomplete or incorrect, they must notify SAIF in writing of the error.

For more detailed information and frequently asked questions about the full process, please visit the SAIF webpage and the A guide to Oregon's workers' compensation benefits, rights, and responsibilities.

SAIF can also be contacted by phone at 800-285-8525.

City of McMinnville

Quick Guide

Things to know when you are injured

Getting Care

- You can pick your own doctor when you first need treatment. SAIF will let you know if you need to change doctors later in the process.
- When receiving care, be sure to let your provider know at check-in that this is work related injury and the insurance carrier is SAIF.
- If aren't sure if you should seek medical attention, you can call Rapid Care at (855) 959-2741. Rapid Care is available 24/7 and can recommend immediate care instructions.

Getting Medication

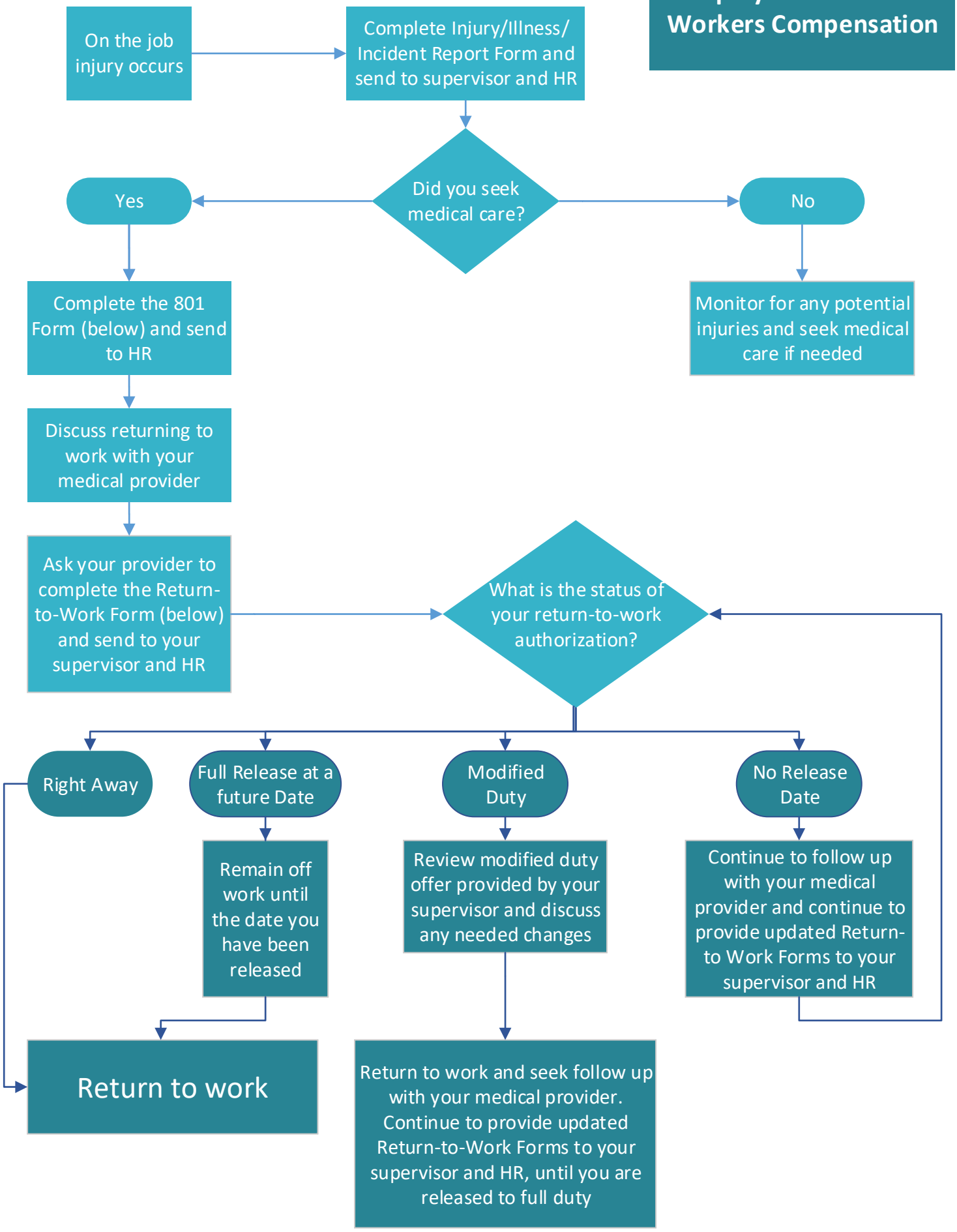
- SAIF's First Fill pharmacy program provides a limited number of cost-effective prescription drugs for work-related injuries or illnesses until a decision has been made on your claim.
- There will be no out-of-pocket costs to you for the prescriptions covered by First Fill. If you pay for any prescribed medications up until a decision is made on your claim, you can request reimbursement for them. **However, you can be reimbursed only if your claim is accepted, and you must have itemized receipts to get reimbursed.**
- View the First Fill prescription drug list:
  - https://www.saif.com/worker/first-fill-prescription-drug-list.html

saif Work. Life. Oregon.

SAIF Claim

- Your claim will be processed by SAIF. Each claims process is a bit different as it is processed based on the needs of the employee. If you are interested in viewing your claim online, please visit MyClaim. This site allows employees to:
  - Track claim status
  - Request reimbursements
  - View time-loss payments and information
  - Find contact information for SAIF and your medical providers
    - https://www.saif.com/worker/the-claim-process/myclaim.html

Employee Process for Workers Compensation



Injury/Illness/Incident Report Form

Use this form to report all injuries, illnesses, or "near miss" (could have caused an injury or illness). If *you are an employee and will be seeking medical treatment, you must also complete an 801 form as soon as possible. Contact Human Resources (HR) or your Supervisor for additional information.*

Injured Person Information				
Name				
Primary Personal Phone				
Relationship to the City				
Date of Injury		Time of Injury		☐ am ☐ pm
Location of Injury				
Transported for Medical Treatment?	☐ Yes ☐ No	If yes, by who?		
Was 911 called?	☐ Yes ☐ No			

Incident Information
Please describe, in detail, what happened (attach another sheet, if needed):
Please indicate which body parts are injured:

Injured Person Signature	**Date**

Witness Information (if any)			
Name		Phone Number	
Name		Phone Number	
Name		Phone Number	

saif

400 High St. SE
Salem, OR 97312

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

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

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. Language preference:	13. Birthdate: / /	14. Gender: ☐ M ☐ F
15. Your mailing address: City: State: ZIP:			16. Mobile/home phone:
17. Occupation:			18. Work phone:
19. Names of witnesses:	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? ☐ Yes ☐ No			
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 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**.

27. Worker signature:	28. Completed by (please print):	29. Date: / /

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: City of McMinnville	31. Phone: (503) 434-7405	32. FEIN: 936002204
33. If worker leasing company, list client business name:		34. Client FEIN:
35. Address of principal place of business (not P.O. Box): 230 NE 2nd St, McMinnville, OR 97128		36. Insurance policy no.: 100034807
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? ☐ Yes ☐ No		41. Class code:
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ 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 ☐ ☐ 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: / /

801
Form 801 12.20

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.*

RESET

PRINT

Return form to:

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ **Yes** ☐ **No**

WORK STATUS *(Select one option)*

☐ **OPTION 1 Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: _____hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____