Oregon Nonprofit Employers Trust
c/o Empire Pacific Risk Management, Inc.
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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 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: ☐ a.m. ☐ p.m.	Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:**
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you are employed by more than one employer: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐Left ☐Right				Occ
				Nat
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)				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 ☐ F ☐
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? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

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(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

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:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. box):		Insurance policy no.:
Street address from which worker is/was supervised: **ZIP**:		Nature of business in which worker is/was supervised:
Address where event occurred:		

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No				
Were other workers injured? ☐ Yes ☐ 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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