

**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> Emp. Ins Occ Nat Part Ev Src 2src	
Time of injury/illness:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Time you left work:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Check here if you are employed by more than one employer: <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <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
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)						

**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: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<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: 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.</b>		
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:	<b>ZIP:</b>	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? <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: \$
Employer signature:	Name and title (please print):	Date:
		If fatal, date of death:

**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.

**Oregon Contractors Workers Compensation Trust**  
**c/o Alliant Specialty Insurance Services**  
**P.O. Box 82175**  
**Portland, OR 97282**  
**503-922-4727**

## Reporte de Lesión o Enfermedad en el Trabajo

(Report of Job Injury or Illness)

Reclamación de compensación para trabajadores  
 (Workers' compensation claim)

### Trabajador (Worker)

Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte del formulario para el trabajador y entregela a su empleador. **Si usted no tiene la intención de hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea para su firma.** Su empleador le dará una copia. (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. )

Fecha de la lesión o enfermedad (Date of injury or illness):	Fecha que dejó el trabajo (Date you left work):	Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury): <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Días que regularmente no trabaja (Regularly scheduled days off): <input type="checkbox"/> <input type="checkbox"/> <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	<b>DEPT USE:</b>
				Emp
Hora en la que ocurrió la lesión o enfermedad (Time of injury/illness): <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Hora que dejó el trabajo (Time you left work): <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Marque este casillero si usted tiene más de un empleador. (Check here if you are employed by more than one employer): <input type="checkbox"/>	Ins	
Cuál es su lesión o enfermedad? En qué parte del cuerpo? Qué lado? (Ejemplo: torcedura del pie derecho) What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) <input type="checkbox"/> Izquierdo (Left) <input type="checkbox"/> Derecha (Right)				Occ
Cuál fue la causa? Qué estaba haciendo? Incluya vehículo, maquinaria o herramienta usada. (Ejemplo: caí diez pies mientras subía una escalera de extensión cargando una caja de herramientas que pesaba 40 libras) 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): - -				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.**

Su nombre legal (Your legal name):	Fecha de nacimiento (Birthdate):	Sexo (Gender): <input type="checkbox"/> M <input type="checkbox"/> F
------------------------------------	----------------------------------	---

Su dirección postal (Your mailing address): 1202	Teléfono del domicilio (Home phone):
--	--------------------------------------

Número de Seguro Social (opcional) SSN (optional):	Ocupación (Occupation):	Teléfono del trabajo (Work phone):
--	-------------------------	------------------------------------

Nombres de testigos (Names of witnesses):

Nombre del médico o profesional del cuidado medico (Name of physician or health-care professional):	Si le dieron tratamiento médico fuera del lugar de trabajo, anote el nombre y dirección del lugar (If medical treatment was given away from the worksite, print name and address of facility):
Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Con mi firma:** Estoy dando aviso de reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos para liberar los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y el Departamento para Consumidores y Negocios de Oregon. **Aviso:** Expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPAA no es requerida (45 CFR 164.512(I)). Para compartir récords sobre el HIV/AIDS (SIDA), récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.

**(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. )

Firma del trabajador (Worker signature):	Completada por (Completed by) Por favor escriba (please print):	Fecha (Date):
---	--	------------------

## Empleador (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? <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.

440-801S (8/04 tr 11/04/DCBS/WCD/WEB)

# 801S



**Oregon Contractors**  
**WORKERS' COMPENSATION TRUST**

**EMPLOYEE'S INCIDENT OR INJURY**

Please complete the following in your own words:

Your Name: \_\_\_\_\_ Department: \_\_\_\_\_

1. Where did the incident/injury occur? (Please be specific in location)
2. When did the incident/injury occur? Time: \_\_\_:\_\_\_ \_\_am \_\_pm Date: \_\_/\_\_/\_\_
3. Describe how the incident occurred.
4. Describe in detail all of the parts of your body that were injured.
5. What caused the incident or injury?
6. List any protective equipment you were using or wearing when the incident occurred.

**THIS IS A TRUE AND ACCURATE STATEMENT, IN MY OWN WORDS, WHICH DESCRIBES MY INCIDENT AND/OR INURIES.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Injured Employee)*

PLEASE SUBMIT THIS REPORT WITHIN 24 HOURS OF INCIDENT



# Oregon Contractors

## WORKERS' COMPENSATION TRUST

### SUPERVISOR INDUSTRIAL INJURY INVESTIGATION REPORT

Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Department: \_\_\_\_\_  
Supervisor Name/Title: \_\_\_\_\_

Name of Employee Injured: \_\_\_\_\_  
(First Name) (MI) (Last Name)

Employee Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth? \_\_\_\_\_ Date of Hire? \_\_\_\_\_

When Did the Injury Occur? \_\_\_\_\_ AM / PM  
(Date) (Time)

Specific Body Parts Involved \_\_\_\_\_  
\_\_\_\_\_

How Did the Injury Occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Oregon Contractors

## WORKERS' COMPENSATION TRUST

Where Did the Injury Occur? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Was There Any Involvement of a Third Party? If so, please provide information:**

Yes

\_\_\_\_\_  
(Third Party Name)

No

\_\_\_\_\_  
(Third Party Address)

\_\_\_\_\_  
(Third Party Phone Number)

**Were There Any Witnesses to the Injury? If so, please provide information:**

Yes

\_\_\_\_\_  
(Witness #1)

No

\_\_\_\_\_  
(Witness #2)

\_\_\_\_\_  
(Witness #3)

What Steps Have Been Taken to Prevent Recurrence of the Injury? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



# Oregon Contractors

---

## WORKERS' COMPENSATION TRUST

---

Was The Employee Referred for Medical Treatment? If so, please provide information:

Yes

\_\_\_\_\_ (Name of Facility/Doctor)

No

\_\_\_\_\_ (Address)

\_\_\_\_\_ (Address)

**Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*By signing this form, the employee acknowledges that he/she agrees that the contents are true and correct to the best of his or her knowledge.*