saifcorporation
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

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. Time you began work on day of injury: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off:	DEPT USE:
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.	☐M ☐T ☐W ☐T ☐F ☐S ☐S	Emp
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: ☐	Ins
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)				Occ
				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. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	13. Birthdate:	14. Gender: ☐ M ☐ F
15. Your mailing address, city, state and zip:			16. Home phone:
17. Social Security no. (see back*):	18. Occupation:		19. Work phone:
20. Names of witnesses:			

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.

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

30. Employer legal business name:	31. Phone:	32. FEIN:
33. If worker leasing company, list client business name:		34. Client FEIN:
35. Address of principal place of business (not P.O. Box):		36. Insurance policy no.:
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 notified 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:			50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
51. Employer signature:	52. Name and title (please print):		53. Date:

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OSHA requirements: On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.

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