

Notice to worker: Failure to file a claim with your employer within 90 days of injury or within one year of learning you have an occupational disease may result in claim denial. Please read about your rights and responsibilities on the back of this form.

Notice to employer: Failure to report a claim to your insurance company within five days of knowledge of the claim may result in untimely payment of time-loss benefits to the worker and a penalty to you or your insurance company. Submit the claim even if the worker is unavailable, unable to provide information, or unable to sign the form.

Guidelines for completing the 801

Use a ballpoint pen, press firmly, and write clearly, or use a typewriter. The numbered items below correspond to those on the 801 and may help you complete the claim form.

Worker section

7. Enter the number of years of education you have completed (GED is 12.)
8. If you were hospitalized past midnight for treatment and lodging, check "Yes."
9. Provide the type of injury (example: **cut** leg, **broken** arm).
11. Identify the body part(s) injured (example: low **back**, **leg** - right, **shoulder** - left, etc.).
13. Provide the actual date of accident, if an injury, or the date your condition first required medical attention, if an occupational disease.
15. If "Yes," briefly describe the prior injury (example: car accident in 1995, work injury in 1996, etc.).
17. Describe the accident as completely as possible. This will help the insurance company handling your claim.
18. Read "**Important information about your Social Security Number (SSN)**," "**Authorization to release medical records**," and "**Caution against making false statements**," on the back of the 801.

Employer section

20. A Business Identification Number (BIN) is assigned by the Oregon Department of Revenue and is printed on your Oregon Tax Coupons (OTCs).
22. FEIN is your Federal Employers Identification Number.
- 24-27. If you are a "worker leasing company" as defined in Oregon Revised Statute 656.850(1), the businesses you provide workers to are your "clients." Complete this section only if your worker was injured while leased to a client.
28. Examples: truck manufacturing, retail grocery, log hauling, etc.
29. Enter the payroll class code under which you report this worker's earnings to your workers' compensation insurer.
33. Report the earliest of the following:
 - the date you first knew of a claim
 - the date you first knew of an accident or disease that may result in a compensable injury that requires medical services or causes time loss, permanent disability, or death
37. See 24-27 above, for definition of "client."
50. Examples: "Loading dock, north end" or "Client's office at 452 Monroe Street, Washington, D.C., 20210."
51. Examples: acetylene cutting torch, metal plate.
52. Example: "Cutting metal plate for flooring." (Indicate whether or not activity was part of normal job duties.)
53. Example: "Worker stepped back to inspect work and slipped on some scrap metal. As she fell, worker brushed against the hot metal."
56. Check "Yes" if the worker presented a Preferred Worker Eligibility Card to you at the time of hire or you received a "Notice of Premium Exemption" from the Workers' Compensation Division (and the injury occurred on or before the eligibility end date on the card or notice).

This form satisfies OSHA
Form 101 record-
keeping requirements.
See reverse.

Si Ud. tiene preguntas relacionadas a este formulario, comuníquese con la División de Compensación para Trabajadores, Sección de Beneficios, en Salem al número telefónico (503) 947-7585, TTY: (503) 947-7993, o (llamada gratis en Oregon) (800) 452-0288.

If you have questions about this form, call the Workers' Compensation Division, Benefits Section, in Salem at (503) 947-7585, TTY: (503) 947-7993, or toll-free in Oregon: (800) 452-0288.

OSHA Recordkeeping Guidelines

Recordable Cases

If you are subject to recordkeeping regulations, you are required to record information on OSHA Form 200 about: (1) every occupational fatality; (2) every nonfatal occupational illness; and (3) those nonfatal occupational injuries that involve one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment other than first aid (see guidelines below).

Nature of injury	Medical treatment (recordable)	First aid (non-recordable)
<p>Cuts, lacerations, punctures, abrasions, splinters</p>	<ul style="list-style-type: none"> Sutures (stitches) Butterfly adhesive dressing(s) or steri strip(s) in lieu of sutures Treatment of infection Application of antiseptic on second or subsequent visit to a doctor or nurse Removal of foreign bodies requiring skilled services of physician due to depth of embedment, size or shape of object(s), or location of wound Removal of foreign bodies embedded in eye Cutting away dead skin (surgical debridement) 	<ul style="list-style-type: none"> Bandaging on any visit to doctor or nurse Application of antiseptic on first visit to doctor or nurse Application of ointments on first or subsequent visits to prevent drying or cracking of skin Removal of foreign bodies from wound by tweezers or other simple techniques Removal of foreign bodies in the eye, not embedded, by irrigation
<p>Fractures</p>	<ul style="list-style-type: none"> When X-ray results are positive Application of a cast or other professional means of immobilizing the injured part is required 	<ul style="list-style-type: none"> When X-ray taken as a precaution is negative for fracture
<p>Strains, sprains, dislocations</p> <p>Any strain, sprain, or dislocation is recordable if the worker's range of motion is affected in a manner that prevents the worker from doing regularly assigned duties, whether or not medical treatment is rendered.</p>	<ul style="list-style-type: none"> Application of a cast or other professional means of immobilizing injured part Use of hot or cold compresses for treatment of strains, sprains, and dislocation on second or subsequent visits to a doctor or nurse Use of diathermy and whirlpool treatments on second or subsequent visits to a doctor or nurse A series of chiropractic treatments 	<ul style="list-style-type: none"> Use of an elastic (Ace) bandage on a strain that is not otherwise recordable, on a first visit to a doctor or nurse Use of hot or cold compresses for treatment of a strain on first visit to a doctor or nurse Use of diathermy and whirlpool treatments on first visit to doctor or nurse A single chiropractic treatment for minor injury or discomfort
<p>Thermal or chemical burns</p> <p>Any burn is recordable if the worker's range of motion is affected in a manner that prevents the worker from doing his or her regularly assigned duties, whether or not medical treatment is rendered.</p>	<ul style="list-style-type: none"> Treatment of all second- and third-degree burns 	<ul style="list-style-type: none"> Treatment by a doctor or nurse for a first-degree burn
<p>Bruises, contusions</p> <p>Any bruise or contusion is recordable if the worker's range of motion is affected in a manner that prevents the worker from doing regularly assigned duties, whether or not medical treatment is rendered.</p>	<ul style="list-style-type: none"> Treatment of a bruise by draining collected blood Soaking or application of cold compresses to a bruise on second or subsequent visits to a doctor or nurse 	<ul style="list-style-type: none"> Soaking or application of cold compresses to a bruise, that is otherwise not recordable, on first visit to a doctor or nurse

Miscellaneous procedures

Medical treatment is only one criteria for determining recordability. Any injury that required only first-aid treatment but involved loss of consciousness, restriction of work or motion or transfer to another job is recordable.

- Tetanus shots**, either initial shots or boosters, are considered preventive in nature and are **not** considered medical treatment.
- Hospitalization for observation**, where no treatment is rendered other than first aid, is **not** considered medical treatment. However, most injuries requiring hospitalization will result in lost workdays and will be recordable for that reason.
- The **observation of injury** by a doctor or nurse is **not** recordable.
- Giving worker prescriptions for drugs on second or subsequent visits constitutes medical treatment. Use of prescription medication, when a single dose is administered on the first visit for minor injury or discomfort, is **not** recordable. Recommending or giving nonprescription medicines is considered first aid.
- All **diagnosed occupational illnesses** are recordable.
- All **occupational fatalities** are recordable.
- A **heart attack**, if determined to be work-related is recorded as an illness (col 7g and col 8 of log).
- Replacement of broken eyeglasses in itself is **not** recordable.

OSHA recordkeeping questions may be referred to:

Department of Consumer & Business Services,
 Information Management Division
 350 Winter St. NE, Salem, OR 97301-3880
 Phone: (503) 378-8254

**State of Oregon
Worker's and Employer's
Report of Occupational
Injury or Disease**

FEIN of claim administrator:

Insurer claim number:

Complete all items — Failure to do so may delay benefits

See information on back.

WORKER

1. Worker's legal name (first, m.i., last):		2. Home phone: ()	3. Date of birth:	4. Social Security number (see back of form):	
5. Worker's street, mailing, and e-mail address: City State ZIP		6. Male <input type="checkbox"/> Female <input type="checkbox"/>	7. Education — grade completed: (0 – 20)	8. Hospitalized overnight as inpatient? (If emergency room-only, mark "No") <input type="checkbox"/> Yes <input type="checkbox"/> No	
		9. Nature of injury/disease (strain, cut, bruise, etc.):		10. Name and city of hospital:	
		11. Body part(s) affected: <input type="checkbox"/> Left <input type="checkbox"/> Right		12. Name and address of health insurance provider:	
13. Date of injury/disease:	14. Time of injury: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	15. Has body part been injured before? (If yes, explain) <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Full name, address, and phone no. of attending physician: ()	
17. Describe accident fully (please print)					
Witness(es):					

18. By my signature I am giving NOTICE OF CLAIM and authorizing medical providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief (see paragraphs 3 and 4 on the back). By my signature, I also authorize the use of my SSN as described in paragraph 2 on the back. (If you do not authorize the use of your SSN as described in paragraph 2 on back, check here .)

Worker: Sign and give form to your employer for completion

Worker signature _____ *Date* _____

This form satisfies OSHA Form 101 recordkeeping requirements. EMPLOYER

19. Employer's legal business name:		20. Employer BIN:		<i>Employer: Complete items 24-27 only if worker is a leased employee.</i>		Dept. use								
21. Employer's street and email address: City State ZIP		22. Employer FEIN:		24. Client's legal business name:		25. Client BIN: Emp no								
		23. Insurer policy #:		26. Client's street and email address: City State ZIP		27. Client FEIN: Ins no								
28. Nature of business:		29. Worker class code:				Occ								
30. Worker's occupation (do not abbreviate):		31. Is worker an owner or corp. officer? <input type="checkbox"/> Yes <input type="checkbox"/> No		32. Address of injury site if different from 21 or 26: City State ZIP		Nature								
33. Date employer first knew of claim:		34. If fatal, date of death:				Part								
35. Date of hire:		36. State of hire:		37. Injured on employer's or client's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Event								
				38. Did injury occur during course of job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										
39. Date left work:		40. Time left work: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		41. Date returned to regular work:		Source								
				42. Date returned to work with restrictions/light duty:										
43. Working shift: → from : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. to : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		44. No. of hours worked per shift:		45. If returned to work with restrictions, were full wages paid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Assoc object								
46. Wage and wage period: \$ per <input type="checkbox"/> Hr. <input type="checkbox"/> Day <input type="checkbox"/> Wk. <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.		47. If wage varies or includes other earnings (tips, room and board, commission, etc.) give total weekly wage and explain: (Attach payroll records for last 52 weeks prior to date of injury)				Insurer use								
48. Scheduled days off: <table border="1"><tr><td>S</td><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td></tr></table>		S	S	M	T	W	T	F	49. Number of days worked per week: \$					
S	S	M	T	W	T	F								
50. Department and location where event occurred:		51. All equip., materials, or chemicals employee was using when event occurred:												
52. Specific activity the employee was engaged in when event occurred. (Indicate if activity was part of normal job duties):														
53. How injury or illness occurred; describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:														
54. Was accident caused by person (other than injured worker) or by failure of machinery or product? <input type="checkbox"/> Yes <input type="checkbox"/> No		55. Were other workers injured in the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		56. Is worker "premium exempt" (a Preferred Worker)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," attach copy of eligibility card.)										
57. Signature of employer representative: X		58. Print name, title and phone:				59. Date:								

Attention: Fatalities must be reported to DCBS/OR-OSHA within eight hours of occurrence. Accidents resulting in overnight hospitalization with medical treatment must be reported within 24 hours of employer notification to the DCBS/OR-OSHA local field office. Report fatalities or accidents by calling (503) 378-3272. After 5 p.m., before 8 a.m., and on holidays and weekends, report by calling Oregon Emergency Response, (800) 452-0311.

Original and copy to insurer within 5 days of notice of claim; copy to worker immediately as receipt of claim; copy to employer's file.

Insurer's Copy

801



**State of Oregon
Worker's and Employer's
Report of Occupational
Injury or Disease**

FEIN of claim administrator:

Insurer claim number:

Complete all items — Failure to do so may delay benefits

See information on back.

WORKER

1. Worker's legal name (first, m.i., last):		2. Home phone: ()	3. Date of birth:	4. Social Security number (see back of form):	
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		9. Nature of injury/disease (strain, cut, bruise, etc.):		10. Name and city of hospital:	
		11. Body part(s) affected: <input type="checkbox"/> Left <input type="checkbox"/> Right		12. Name and address of health insurance provider:	
13. Date of injury/disease:	14. Time of injury: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	15. Has body part been injured before? (If yes, explain) <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Full name, address, and phone no. of attending physician: ()	
17. Describe accident fully (please print)					
Witness(es):					

18. By my signature I am giving NOTICE OF CLAIM and authorizing medical providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief (see paragraphs 3 and 4 on the back). By my signature, I also authorize the use of my SSN as described in paragraph 2 on the back. (If you do not authorize the use of your SSN as described in paragraph 2 on back, check here .)

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28. Nature of business:		29. Worker class code:				Occ								
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52. Specific activity the employee was engaged in when event occurred. (Indicate if activity was part of normal job duties):														
53. How injury or illness occurred; describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:														
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Original and copy to insurer within 5 days of notice of claim; *copy to worker* immediately as receipt of claim; *copy to employer's* file.



440-801 (1/00/COM)

**Worker's
Copy**

801

Notice to Worker

Important information about your Social Security Number (SSN)

1. You must provide your SSN. The Workers' Compensation Division (WCD) of the Department of Consumer and Business Services (DCBS) has authority to request your SSN under the Privacy Act of 1974, 5 USC & 552a (West 1977), Section 7(a)(2)(B). Authority under state law is provided in Oregon Revised Statute 656.265 and under Administrative Order WCB 4-1967 codified at OAR 436 Division 060. Your SSN will be used by DCBS to carry out its duties under ORS Chapter 656, which include compliance, research, claims processing, and injured-worker-program administration.

2. Your voluntary authorization for the use of your SSN is also requested for use by various government agencies to carry out their statutory duties, including, but not limited to, planning, research, child support enforcement, employment assistance, benefit coordination, child labor law enforcement, risk management, hazard identification, rate setting, and training programs. If you do not authorize this use, please check the box by your signature in Section 18 on the front of this form.

Authorization to release medical records

3. By signing this 801, you are giving "Notice of Claim" and authorizing medical providers and other custodians of claim record to release records related to the injury or disease claimed on this 801 under ORS Chapter 656 and OAR Chapter 436. Medical information relevant to the claim includes past history of the complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part.

Caution against making false statements

4. Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment is punishable, upon conviction, by imprisonment for a term of not more than one year, a fine of not more than \$1,000, or both, under ORS 656.990(1).

This is your receipt, when signed by your employer, that you gave notice of a claim. Keep it as your record.

5. Your employer will submit the claim for you. You will receive written notice from your employer's insurer of any action taken on your claim. If your employer is self-insured, the notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. The insurer must notify you of its acceptance or denial within 90 days from the date your employer knows of your claim. If denied, the reason for the denial and your rights will be explained.

Medical care

6. If your claim is accepted, the insurer or self-insured employer will pay injury-related medical bills, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses paid by you for claim-related treatment, up to an established maximum. Your request for reimbursement must be in writing and include receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with the following exceptions: If you are required by your insurer to receive treatment from a managed care organization (MCO), necessary medical care, not otherwise covered by your health insurance, will be paid by your insurer until you receive a notice of denial or until three days after the insurer mails the notice of denial to you, whichever occurs first.

You must tell your doctor or hospital on your first visit that your injury or illness is work related. The doctor must tell you if there are any limits to the medical services he or she may provide you under the Oregon workers' compensation system.

If you are enrolled in a managed care organization (MCO), your attending physician may be any medical service provider authorized by contract with the MCO. An MCO contracts with insurance companies to provide managed medical care to injured workers of employers covered by the insurance company. Check with the MCO to find out who can be your attending physician. If you are not enrolled in an MCO, your attending physician must be one of the following:

- A licensed medical doctor, a licensed doctor of osteopathy, or a licensed oral and maxillofacial surgeon
- A licensed chiropractor (only for 30 days from the date of the first chiropractic visit on the initial claim or for 12 chiropractic visits during the 30-day period, whichever happens first)

Payments for time lost from work

7. In order for you to receive payments for time lost from work, your attending physician must notify the insurer or self-insured employer of your inability to work. You will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted as an inpatient to a hospital within 14 days of the first onset of total disability.

If you are disabled for more than three calendar days, the insurer or self-insured employer must mail your first compensation check no later than the 14th day after your employer knows of your claim. You will continue to receive a check every two weeks during your recovery period as long as your attending physician verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum equal to Oregon's average weekly wage. However, if your weekly wage is \$75 or less, your benefits will be \$50 per week or 90 percent of your weekly wage, whichever is less.

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

Workers' Compensation Division

350 Winter Street NE, Rm. 27, Salem, OR 97301-3879
Call Salem: (503) 947-7585, TTY: (503) 947-7993,
or toll-free in Oregon: (800) 452-0288

OR

Ombudsman for Injured Workers

350 Winter Street NE, Salem, OR 97301-3878
(503) 378-3351, TTY: (503) 947-7189,
or toll-free: (800) 927-1271