Filling an Out On-the-Job Injury Packet

If medical treatment is sought for an on-the-job injury and the injured worker wishes to file a workers' compensation claim, the entire On the Job Injury Packet must be completed and submitted to the Workers' Compensation Administrator **within 24 hours**.

If an injured worker seeks medical treatment, i.e. at the emergency room or from a doctor, but does **not** wish to file a workers' compensation claim, only the Supervisor's Accident/Injury Investigation Report (Form LC03) must be submitted to the Workers' Compensation Administrator within 24 hours.

NOTE: If an injured worker seeks medical treatment for an on-the-job injury, they must provide a work release to the supervisor.

Workers' Compensation Administrator (WCA) Contact Information

Phone: 541 682 3660 **Fax: 541 682 9828** **Email: WCAdmin@co.lane.or.us**

Injured Worker

1. Complete top half of Form 801.
2. Complete shaded areas of the Medical Release (Form LC01) (worker's name, date of injury, signature and date of signature only).
3. Complete and sign the Employee/Claimant Responsibilities sheet (FORM LC02)
4. Sign pages two and four of the Supervisor's Accident/Injury Investigation Report (Form LC03).
5. Give completed forms to supervisor**.

Supervisor

1. Complete the top half of the Form 801 if the injured worker is unable or not available to complete the form.
2. Complete bottom half of the Form 801 leaving Location/Department and Union boxes blank. NOTE: Date employer knew of claim is the date you first learned the injured worker wished to file a workers' compensation claim. This may not be the same date as when you learned the worker was seeking medical treatment.
3. Review Employee/Claimant Responsibilities sheet (Form LC02) with injured worker.
4. Sign Form LC02.
5. Give copy of Form LC02 and "A Guide for Workers Recently Hurt on the Job" page to injured worker.
6. Complete all four pages of the Supervisor's Accident/Injury Investigation Report (Form LC03).
7. Submit all forms, to the Division Manager** within 12 hours of the injury.

Division Manager

1. Review forms.
2. Sign page four of the Supervisor's Accident/Injury Investigation Report (Form LC03).
3. Submit all forms within 24 hours of the injury to the WCA via fax or email.
4. Sends originals of all forms via courier to the WCA in County Administration.

If the supervisor or Division Manager is not available, please go up the chain of command for processing. Staff absence is **not an acceptable explanation for delay.

NOTE: Incomplete forms or forms with vague explanations will result in contact from Risk Management for completion or clarification.

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer about your job-related injury or illness as soon as possible.
- Ask your employer to give you **Form 801, "Report of Job Injury or Illness,"** and complete Form 801.
- Ask your employer the name of its workers' compensation insurer. Lane County uses MATRIX in Portland.
- Get medical treatment from a health care provider **of your choice** and tell your provider that you were injured on the job. Your employer cannot choose your health care provider for you.
- Your health care provider should ask you to complete **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims."**

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified or light duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.

  Lane County:

  Workers' Comp Administrator: 541-682-3660
  Email: WCAdmin@co.lane.or.us.

- You may also call any of the numbers below:

  Ombudsman for Injured Workers:
  An advocate for injured workers
  Toll-free: (800) 927-1271
  E-mail: oiw.questions@state.or.us

  Workers' Compensation Infoline:
  Benefit Consultants
  Toll-free: (800) 452-0288
  E-mail: workcomp.questions@state.or.us

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

Submit this form to WCAdmin@co.lane.or.us within 24 hours of injury.

MATRIX
10220 SW Greenburg Street – Suite 501
Portland OR 97223-5509
Phone (503) 977-3635

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:** Emp
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: ☐		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: 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	Med Express:	
Were you treated in the emergency room? ☐ Yes ☐ No	☐ Treat on-site ☐ Transport ☐ Not used	

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: **Lane County** Loc. Dept.		Phone: -	FEIN: **93-6002303**
Union:	Scheduled shift: Hours per Week:		Client FEIN:
Address of principal place of business (not P.O. box):			Insurance policy no.: **SI-1444**
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.

801

Request for Release of Medical Records for Oregon Workers' Compensation Claim

Submit this form to WCAdmin@co.lane.or.us within 24 hours of injury.

Injured Worker fills out shaded areas.

To: Custodian of medical records

Name: _____

Address: _____

_____

Worker information

Name: _____

Insurer claim number: _____

Date of injury: _____

Worker authorization/signature

By my signature, I authorize medical providers and other(see below) to the requester named below, as provided in ORS 656.252, OAR 436-010-0240 and OAR 436-060-0017. **Medical information relevant to the claim includes a past history of complaints or treatments of a condition similar to that presented in the claim or other conditions related to the same body part.**

Worker's signature: _____ *Date*: _____

Claimed conditions (Requester: List below; be specific.)

Please include any and all information regarding the timing, rescheduling, cancellation and no show of/for appointments and the reasons for these events.

Separate authorization is required for release of the following information

- The worker's participation in federally funded drug and alcohol abuse treatment programs under Federal Regulation 42, CFR 2.
- HIV-related information protected by ORS 433.045(3).

OAR 436-010-0240 requires that medical providers respond to a request for medical records within 14 days of the date of the request. Failure to respond within 14 days to a request sent by certified mail may subject the medical provider to penalties under OAR 436-010-0340 or 436-015-0120. This request is being sent on_____.

Please send relevant medical records by _____ to:

Requester's name: _____

Attention: _____

Address: _____ Phone no.: _____

_____ Fax no.: _____

Note: People who release medical information in accordance with Oregon Administrative Rules shall bear no legal liability for such disclosure.

2476

LC01

Submit this form to WCAdmin@co.lane.or.us within 24 hours of injury.

On-the-Job Injury: Employee/Claimant Responsibilities

Initial in the spaces provided

____ I will keep my supervisor and the Lane County Workers' Compensation Administrator (WCA) informed of any restrictions that my treating provider may place on me. **I understand that work within these restrictions may be available.** I also understand that refusal of work within the physician approved restrictions may result in termination of time loss benefits. A Work Status Report (also known as a "release") needs to be provided to my supervisor BEFORE I RESUME WORK FOLLOWING AN APPOINTMENT.

____ If I am unable to work, I must provide my supervisor and the WCA with a note from my treating physician. **ALL TIME LOSS NEEDS TO BE AUTHORIZED IN WRITING BY MY ATTENDING PHYSICIAN.** I will provide this documentation to the WCA within 24 hours of receiving it or no later than the next working day. I will provide a "full release" prior to resuming regular duty work.

____ I will follow my physician's advice and restrictions and remember that they apply to my everyday life, not just during work.

____ I will inform my supervisor and the WCA if my appointment(s) conflict with work time. If time is missed from work for an appointment, I will code the time missed to TM/Comp/Personal Time and submit documentation of my appointment attendance to the WCA within 24 hours. I understand that if my absence goes beyond 1.5 hours (including travel time), a note from my physician will be required to justify the additional time.

____ I will inform the WCA of any future medical appointments within 24 hours of the time they are made.

____ I understand that my workers' compensation claim will be fully investigated and that I may be contacted by an investigator contracted by Lane County to interview me regarding my workers' compensation claim.

____ I understand that if my claim is denied, I may be responsible for payment of my medical treatment.

____ I understand that I am required to cooperate in the processing of this claim. I agree that cooperation includes, but is not limited to: promptly filling out requested paperwork, providing medical records and releases, making myself available for interviews and attending appointments. I understand that failure to cooperate could result in penalties and/or a denial of benefits.

____ I have read and understand the provisions initialed above and have been provided a copy.

Employee: _____ _____ _____
Signature Printed Name Date

Employee ID # _____ Department/Division _____

I have provided a copy of this document and the "A Guide to Workers Recently Hurt on the Job" page to the injured worker.

Supervisor: _____ _____ _____
Signature Printed Name Date

Lane County Workers' Compensation Administrator

Phone: 541-682-3660 FAX: 541-682-9828 Email: WCAdmin@co.lane.or.us

LC02

Revised 2/24/2014

SUPERVISOR'S ACCIDENT/INJURY INVESTIGATION REPORT

This form should be completed by the supervisor not the injured worker.

GENERAL INFORMATION

1. Name of employee(s) involved in the accident

   _____

   _____

2. Nature of accident (**-X-** ALL that apply)

   ☐ Injury / Illness (801 Form)
   ☐ Equipment Damage
   ☐ Property Damage
   ☐ Non-County Personnel (Third Party) Involvement

3. Department _____

4. Division _____

5. Date of accident _____

6. Work Unit/Section _____

7. Time of accident _____ ☐ AM ☐ PM

8. Supv. Name _____

9. Date reported _____

10. Specific location of accident (road, street, worksite, etc.)

    _____

    _____

11. Was there a delay in reporting the accident?
    ☐ No ☐ Yes - Please give reason for delay

    _____

    _____

12. Did the accident result in overnight hospitalization, more than 3 employees going to the emergency room, or death?

    ☐ No ☐ Yes -Please describe. _____

List Witnesses: _____

COMPLETE FOR EVERY ACCIDENT/INJURY

ACCIDENT/INJURY DESCRIPTION DATA (Describe in detail WHAT HAPPENED/WHO INVOLVED, etc.)

(If you run out of space, attach separate sheet of paper to report.)

Non-County Personnel Info (Complete ONLY if a non-county vehicle or person was involved)

Name: _____ Phone #'s: _____

Address: _____ Insurance Info: _____

Driver's License #: _____ License Plate # _____

Vehicle Owner Name, Address, Phone: _____

Were there any injuries? ☐ No ☐ Yes - Please describe: _____

Describe what was claimed / observed to be damaged or injured _____

Were any pictures taken? ☐ No ☐ Yes - Please include them with this report.

Was the Risk Manager (541-682-3971) notified of the accident? ☐ No ☐ Yes

When? _____ How? _____

Were any utilities involved? If yes, please identify: _____

Witness names: _____

Non-County Vehicles:

#1 Make _____ Model _____ Color _____ License Plate _____

#2 Make _____ Model _____ Color _____ License Plate _____

Was their vehicle towed? ☐ No - Where is it now? _____

☐ Yes - Who towed it and where did they take it? _____

INJURY / ILLNESS DATA (Complete ONLY if an injury / illness occurred with our employee)

13. What *PART(S)* of the body sustained injury/illness? _____

14. What best describes the *NATURE* of the injury/illness? _____

15. What best describes the *CAUSE* of injury/illness? ☐ Over-exertion ☐ Repetitive Movement ☐ Fall ☐ Struck by Object ☐ Other - Describe: _____

16. Describe the unsafe action or condition that caused or contributed to this accident.

_____

17. Was the correct *Personal Protective Equipment (PPE)* being used? ☐ Yes ☐ No ☐ N/A

18. Enter this accident on your department/division injury log.

19. Complete the On-the-Job Injury Packet if the injured worker would like to file a workers' compensation claim. This packet includes Form 801 (Report of Job Injury or Illness).

20. Did accident cause worker to ***miss any time*** from work? ☐ No ☐ Yes - list date(s)/hour(s) missed (Any time off must be authorized by a physician in writing.) _____

At this time: I ☐ **do** / ☐ **do not** plan to seek medical attention. I understand that although I have answered this truthfully at the time, circumstances may change. I have the right to seek medical attention at any time, but understand that I need to inform my supervisor if my answer to this question changes.

Employee's Signature: _____ Date: _____

EQUIPMENT / PROPERTY DAMAGE (Complete ONLY if LC equipment or property was damaged)

20. What specifically was damaged (bumper, grill, etc.)? _____

21. What *TYPE* of equipment was it (dump truck, grader, ladder, etc.)? _____

22. What is the ***LC Vehicle/Equipment Number(s)*** involved? _____

23. What were the *SITE* and *WEATHER* conditions like? (**-X-** ALL that apply.)

ACCIDENT SITE: ☐ pavement ☐ gravel ☐ dirt ☐ dry ☐ wet

☐ muddy ☐ snow ☐ icy ☐ garbage

WEATHER: ☐ sunny ☐ cloudy ☐ raining ☐ foggy ☐ windy ☐ overcast

24. When was your last Defensive Driving class and/or Equipment Operator Training?

☐ During the last year ☐ 1 – 5 years ago ☐ Over 5 years ago ☐ Never

25. Were there other work-related items damaged (laptop, cell phone, etc.)?

☐ No ☐ Yes – please describe and indicate if personally owned or owned by Lane County:

_____

PREVENTION

26. Can you recommend any action to prevent and/or reduce the likelihood of this kind of accident in the future?

27. Were known hazards identified and communicated prior to beginning the activity? ☐ No ☐ Yes

Hazards Identified: _____

28. Any training needed to prevent reoccurrence of this type of accident?

☐ No ☐ Yes - Please describe the specific training needed: _____

29. Was this accident reviewed with your workgroup for prevention purposes? ☐ Yes ☐ No – Please explain:

_____

DMV Requirement:

ONLY drivers involved in an accident resulting in any of the following **MUST** file an Accident & Insurance Report:

- √ Damage to your vehicle is over $1500
- √ Injury (No matter how minor)
- √ Death
- √ Damage to any one person's property over $1500
- √ Any vehicle has damage over $1500 and any vehicle is towed from the scene as a result of damages

Oregon law requires these reports be filed within 72 hours of the accident. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the accident to DMV, it may result in suspension of your driving privileges. If the police department files a police report, you are still required to file your own Accident and Insurance Report with DMV. If you are an out-of-state resident, you are still required to file your own Accident Report with DMV. DMV does not determine fault in an accident, but does post the accident to the driving record of those drivers required to report, unless the vehicle is parked. If you have questions, please call the Accident Unit at (503) 945-5098.

You are personally responsible for filing the DMV report. Lane County is not responsible for any actions taken as a result of your failure to file.

The DMV report can be found at any DMV office or online @ http://www.odot.state.or.us/forms/dmv/32.pdf

If a DMV report is filed, please provide a copy with this report.

I verify that the statements contained in this document are true and complete to the best of my knowledge; I understand that false statements and/or omissions, whether intentional or unintentional, may be subject to disciplinary action, up to and including termination of my employment with Lane County.

Employee's Signature: _____ **Date:** _____

SUPERVISOR RECOMMENDATIONS AND COMMENTS / DIVISION MANAGER APPROVAL:

I verify that the statements contained in this document are true and complete to the best of my knowledge; I understand that false statements and/or omissions, whether intentional or unintentional, may be subject to disciplinary action, up to and including termination of my employment with Lane County.

Supervisor's Signature: _____ **Date:** _____

Division Manager's Signature: _____ **Date:** _____

EMAIL/FAX REPORT TO RISK MANAGEMENT and WC ADMNISTRATOR WITHIN 24 HOURS
LCRISKMG@co.lane.or.us; WCAdmin@co.lane.or.us; Fax 541.682.9828

Route copies (pdf preferable) to: ☐ Risk Management ☐ WC Administrator ☐ Employee
☐ File ☐ Division Manager ☐ Department Director ☐ Fleet Svcs (if Co. vehicle/equipment is damaged)

SEND ORIGINAL REPORT TO RISK MANAGEMENT