SDAO Contact Sheet

Risk Management Staff

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Workers' Comp Claims Staff

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Joe Lee ***	Senior Claims Examiner	800.305.1736	jlee@sdao.com

* *Handles workers' compensation claims for School Districts, Community Colleges, ESD's, and Charter Schools*
** *Handles workers' compensation claims for Special Districts*
*** *Handles workers' compensation claims for Fire Districts, Community Colleges, and ESD's*

Property & Casualty Claims Staff

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Contact Us

SDAO Main Office
PO Box 12613
Salem, OR 97309-0613
800.285.5461 | 503.371.8667
Fax: 503.371.4781

SDAO
SPECIAL DISTRICTS ASSOCIATION OF OREGON

SDAO Claims Office
PO Box 23879
Tigard, Oregon 97281
800.305.1736 | 503.670.7066
Fax: 503.620.6217

Table of Contents

Special Districts Association of Oregon

Through Its Trust: Special Districts Insurance Services (SDIS)

A Self-Insured Employers Group

Workers' Compensation Coverage Document

Effective July 1, 2008

COVERAGE DOCUMENT INDEX

SPECIAL DISTRICTS ASSOCIATION OF OREGON

WORKERS' COMPENSATION COVERAGE DOCUMENT

In consideration for the payment of the contribution by the Named Participant, as defined below, and compliance with all the terms of this coverage document, Special Districts Association of Oregon, through its insurance trust, SDIS, (hereafter "Trust"), a certified self-insured employer group pursuant to 656.430, agrees as follows:

GENERAL SECTION

A. Definitions

"Named Participant's Coverage Declaration" means the document which, in conjunction with the terms, conditions, and exclusions contained within this Coverage Document, as defined below, determines the coverage afforded the Named Participant by the Trust.

"Named Participant" means a member of the Trust identified as the Named Participant in the workers' compensation Named Participant's Coverage Declaration who has paid its contribution and thereby elected to be a part of the Trust's workers' compensation group.

"Coverage Document" means this document which describes the rights and responsibilities as between Named Participants and the Trust relative to the provision of workers' compensation benefits to the employees of Named Participants.

"NCCI" means the National Council on Compensation Insurance.

"Volunteer worker" means a worker who performs work on a volunteer basis, whether or not the worker receives a stipend or nominal reimbursement for time and travel expenses.

"Workers' Compensation Law" means ORS Chapter 656 and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950) in conjunction with all administrative rules promulgated pursuant thereto, and all controlling case law arising thereunder.

B. The Coverage Document

This is a Workers' Compensation Coverage Document under which an individual Named Participant's Coverage Declaration is issued to the Named Participant identified thereon. This Coverage Document delineates the workers' compensation benefits, rights and responsibilities afforded Named Participants in the Special Districts Insurance Services Trust pursuant to its Trust Agreement, Bylaws and Rules and in accordance with ORS 731.036(4) and ORS chapter 190.

PART ONE (COVERAGE A)
OREGON STATUTORY
WORKERS' COMPENSATION COVERAGE

A. How This Coverage Applies

The Workers' Compensation coverage described herein applies as required by the Workers' Compensation Law as defined above.

B. Who is Covered?

Coverage is provided to employees of the Named Participant, provided however that volunteer workers are not covered unless allowed by law and the Named Participant:

1. Submits to the Trust a resolution from the Named Participant's board electing coverage for the Named Participant's volunteer workers;
2. Submits to the Trust an election form reporting the payroll pertaining to the volunteer workers for each NCCI classification for which the volunteer workers engage in work and coverage is sought; and
3. Maintains and keeps an up to date roster of covered volunteer workers listing the names and NCCI payroll classifications for each such worker, and provides the Trust with an accurate and current copy of the roster on a quarterly basis, or within ten (10) days of any such request by the Trust.

In addition to the above, the Named Participant shall identify and provide in writing to the Trust the proper NCCI payroll classification for each employee for whom coverage is sought. If an employee's work duties fall under more than one payroll classification, all applicable payroll classifications for which coverage is sought must be identified and provided. A Named Participant's failure to do the above may result in cancellation of the Named Participant's participation in the Trust's workers' compensation program, and/or the collection of additional contributions as provided for in Part Four, Subpart D of this Coverage Document.

C. The Trust Will Defend

The Trust has the sole right and duty to defend any claim, proceeding or suit against the Named Participant for benefits payable under Part One of this Coverage Document, and to unilaterally select, contract with and direct resources related thereto. The Trust has the sole right to investigate and settle claims, proceedings or suits against Named Participants arising under the Workers' Compensation Law.

The Trust has no duty to defend a claim, proceeding or suit that is not covered by this Coverage Document.

D. Recovery From Others

The Trust will take reasonable steps to recover the Trust's payments from anyone liable for the injury. The Named Participant has a duty to fully cooperate with and assist the Trust in all attempts to pursue recovery of such payments.

PART TWO (COVERAGE B)
EMPLOYERS LIABILITY COVERAGE (ELC)

A. How This Coverage Applies

ELC applies to bodily injury by accident or bodily injury by disease other than those covered under Part One of this Coverage Document, as follows:

1. The bodily injury must arise out of and in the course of the injured employee's employment with the Named Participant.
2. The employment must be necessary or incidental to the Named Participant's work in the State of Oregon.
3. Bodily injury by accident must occur during the coverage period.
4. Bodily injury by disease must be caused or aggravated by the conditions of the Named Participant's employment. The employee's exposure to the conditions at Participant's place of employment causing or aggravating such bodily injury by disease, must occur during the coverage period.
5. If the Named Participant is sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. Who is Covered?

ELC coverage is provided to the Named Participant with regard to liabilities, as described in this Coverage Document, relating to its employees, provided however that coverage is not provided with regard to liabilities relating to volunteer workers unless allowed by law and the Named Participant:

1. Submits to the Trust a resolution from the Named Participant's board electing coverage for the Named Participant's volunteer workers;
2. Submits to the Trust an election form reporting the payroll pertaining to the volunteer workers for each NCCI classification for which the volunteer workers engage in work and coverage is sought; and
3. Maintains and keeps an up to date roster of covered volunteer workers listing the names and NCCI payroll classifications for each such worker, and provides the Trust with an accurate and current copy of the roster on a quarterly basis, or within ten (10) days of any such request by the Trust.

In addition to the above, the Named Participant shall identify and provide in writing to the Trust the proper NCCI payroll classification for each employee for whom coverage

is sought. If an employee's work duties fall under more than one payroll classification, all applicable payroll classifications for which coverage is sought must be identified and provided. A Named Participant's failure to do the above may result in cancellation of the Named Participant's participation in the Trust's workers' compensation program, and/or the collection of additional contributions as provided for in Part Four, Subpart D of this Coverage Document.

C. The Trust Will Pay

The Trust will pay up to the limit of liability as shown on Part Two (Coverage B) of the Named Participant's Coverage Declaration, as losses because of bodily injury to the Named Participant's employees or covered volunteer workers, provided the bodily injury is covered by this Employers Liability Coverage.

The Trust will pay, where recovery is permitted by law, losses:

1. For care and loss of services;
2. For which the Named Participant is liable to a third party by reason of a claim or suit against such Named Participant by such third party to recover the damages claimed against such third party as a result of injury to the Named Participant's employee; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by the Named Participant; and

4. Because of bodily injury to the Named Participant's employee that arises out of and in the course of employment, claimed against the Named Participant in a capacity other than as employer.

D. Exclusions

Part Two of this Coverage Document does not cover any loss or damages payments arising out of or related to:

1. Liability assumed by any contract or agreement;
2. Punitive or exemplary damages and/or fines arising out of:
    a. Any bodily injury to any employee employed in violation of the law; or
    b. Any bodily injury intentionally caused or aggravated by the Named Participant;
3. For which insurance liability is prohibited by law, or is contrary to public policy;
4. Bodily injury to an employee employed in violation of the law with the actual knowledge or acquiescence of the Named Participant or any of the Named Participant's executive officers or board members
5. Bodily injury intentionally caused or aggravated by the Named Participant;
6. Any obligation imposed by any workers' compensation or occupational disease law (including the Workers' Compensation Law as defined herein), unemployment compensation, or disability benefits law or any similar law;

7. Bodily injury occurring outside the United States of America, its territories or possessions and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
8. Any obligation imposed by any of the following statutes, or any regulations promulgated under them, including any amendments: the Federal Employers' Liability Act (45 USC sections 51–60), the Defense Base Act (42 USC sections 1651–1654), the Longshore and Harbor Workers' Compensation Act (33 USC sections 901–950), the Non-Appropriated Fund Instrumentalities Act (5 USC sections 8171–8173), the Outer Continental Shelf Lands Act (43 USC sections 1331–1356), the Federal Coal Mine Health and Safety Act of 1969 (30 USC sections 901–942) or any other federal workers' or workmen's compensation law or federal occupational disease law;
9. Bodily injury to a master or member of the crew of any vessel;
10. For which you have formally rejected any workers' compensation law, including the Workers' Compensation Law as defined herein;
11. The Named Participant's discharge, coercion, criticism, evaluation, reassignment, discipline, harassment, discrimination against, defamation, or termination of any employee or the Named Participant's personnel policies, practices, omissions or acts;
12. Fines or penalties imposed for violation of law whether state or federal;
13. Bodily injury arising out of termination of employment of any employee; or
14. Bodily injury by disease unless prior to thirty-six (36) months after the end of the coverage period written claim is made or suit is brought against the Named Participant for damages because of such injury or death resulting therefrom.

E. The Trust Will Defend

The Trust has the sole right and duty to defend any claim, proceeding or suit against the Named Participant for benefits payable by Part Two of this Coverage Document and to unilaterally select, contract with and direct resources as necessary. The Trust has the right to investigate and settle claims, proceedings or suits.

The Trust has no duty to defend a claim, proceeding or suit that is not covered by this Coverage Document.

F. The Trust Will Also Pay

The Trust will also pay these costs, in addition to other amounts payable under this coverage document, as part of any claim, proceeding, or suit the Trust defends:

1. Reasonable expenses incurred at the Trust's request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this Coverage Document;
3. Reasonable costs of defense;
4. Interest on a judgment as required by law until the Trust offers the amount due under this Coverage Document; and
5. Expenses the Trust incurs.

G. Other Insurance

The Trust will not pay more than the Trust's share of damages and costs covered by this Coverage Document and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all-remaining insurance and self-insurance will be equal until the loss is paid.

H. Limits of Liability

The Trust's liability to pay for damages is limited. The Trust's limits of liability are shown as Coverage B on the Named Participant's Coverage Declaration.

The Trust will not pay any claims for damages in excess of the limit of liability shown as Coverage B on the Named Participant's Coverage Declaration.

I. Recovery From Others

The Trust has the Named Participant's rights to recover any payment for damages from anyone liable for an injury covered by this Coverage Document. The Named Participant will do everything necessary to protect those rights for the Trust and to help the Trust enforce them.

J. Actions Against The Trust

There will be no right of action against the Trust under this Coverage Document unless:

1. The Named Participant has complied with all the terms of this Coverage Document;
2. The amount the Named Participant owes has been determined with the Trust's consent or by actual trial and final judgment.

This Coverage Document does not give anyone the right to add the Trust as a defendant in an action against the Named Participant to determine their liability. The bankruptcy or insolvency of the Named Participant district will not relieve the Trust of the Trust's obligations under this Part.

PART THREE
THE NAMED PARTICIPANT'S DUTIES IF INJURY OCCURS

The Named Participant has the duty, within 24 hours, to immediately tell the Trust if injury or disease occurs that may be covered by this Coverage Document. If a fatality occurs, the Named Participant has the duty to notify the Trust within eight (8) hours. In the case of injury, disease or fatality, the Named Participant has additional duties, as follows:

1. To provide for immediate medical and other services required by the Workers' Compensation Law;
2. To give the Trust the names and addresses of the injured persons and of witnesses, and other information the Trust may reasonably request;
3. To promptly provide to the Trust all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. To cooperate with and assist in preserving potential rights as requested by the Trust, and in the investigation, settlement or defense or subrogation of any claim, proceeding or suit; and
5. To fully cooperate with the Trust in preserving potential rights in recovering third party damages.

Note: If a Named Participant unilaterally elects to make payments, assume obligations or incur expenses, the Trust will have no duty to reimburse the Named Participant for such payments, obligations, or expenses.

PART FOUR – CONTRIBUTIONS

A. The Trust's Plan

The Trust's rules, rates, rating plans and classifications will determine all contributions for this coverage document.

B. Classifications

The Named Participant's Coverage Declaration page shows the rate and contributions for certain business or work classifications. These classifications were assigned based on an estimate of the exposures the Named Participant would have during the coverage period. If the Participant's actual exposures are not properly described by those classifications, the Trust will assign proper classifications, rates and contributions by endorsement to the Named Participant's Coverage Declaration. The assignment of a proper classification resulting in higher contributions will occur where the misclassification was caused by the Named Participant's failure to provide accurate or complete data. If the Named Participant's operation changes during the policy term, the Named Participant must notify the Trust within ninety (90) days of the change. Failure to notify the Trust will be considered a failure to provide accurate or complete data. Contributions to the Trust or to the Participant based on improper classification may be collected or refunded during the term of the Coverage Document and for twelve (12) months after the term.

C. Remuneration

Contribution for each work classification is determined by multiplying a rate times a contribution basis. Remuneration is the most common contribution basis. This contribution basis includes payroll and all other remuneration paid or payable during the coverage document period for the services of:

1. All the Named Participant's officers and employees engaged in work covered by this Coverage Document; and
2. All other persons engaged in work that could make the Trust liable under Part One (Workers' Compensation Coverage) of this Coverage Document. If the Named Participant does not have payroll records for these persons, the contract price for their services and materials may be used as the contribution basis. This paragraph 2 will not apply if the Named Participant gives the Trust proof that the employers of these persons have satisfied their obligations under the Workers' Compensation Law by lawfully securing insurance or appropriately self-insuring for any damages covered under the Workers' Compensation Law.

D. Final Contribution

The contribution shown on the Named Participant's Coverage Declaration is an estimate. The final contribution will be determined after the coverage term ends by using the actual, not the estimated, contribution basis and the proper classifications and rates that apply to the business and work covered by this Coverage Document. If the final contribution is more than the contribution the Named Participant paid to the Trust, the Named Participant must pay the Trust the balance. If it is less, the Trust will refund the balance to the Named Participant.

If this coverage is canceled, final contribution will be determined in the following way unless the Trusts plan provides otherwise:

1. If the Trust cancels coverage of a Named Participant, final contributions will be calculated pro rata based on the time this Coverage Document was in force. Final contributions will not be less than the pro rata share of the minimum contribution.
2. If the Named Participant cancels, final contribution will be more than pro rata; it will be based on the time this Coverage Document was in force and increased by the Trust's short-rate cancellation table and procedure. Final contribution will not be less than the minimum contribution.

E. Records

The Named Participant will keep records of information needed to compute contributions. The Named Participant will provide the Trust with copies of those records when the Trust asks for them.

F. Audit

The Named Participant will let the Trust examine and audit all of the Named Participant's records that relate to this Coverage Document and any information utilized to provide coverage hereunder. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. The Trust may conduct the audits during regular business hours during the Coverage Document period and within three (3) years after the Coverage Document period ends. Information developed by audit will be used to determine final contribution.

PART FIVE – CONDITIONS

A. Inspection

The Trust may inspect the Named Participant's workplace at any time. The Trust may give the Named Participant reports on the conditions the Trust finds and may also recommend changes. While the Trust may help reduce losses, the Trust does not undertake to perform the duty of any person to provide for the health or safety of the Named Participant's employees or the public beyond those required of the Trust by ORS chapter 656 and ORS chapter 654. The Trust does not warrant that the Named Participant's workplaces are safe or healthful or that the Named Participant complies with laws, regulations, codes or standards.

B. Transfer of Your Rights and Duties

The Named Participant's rights or duties under this coverage document may not be transferred without the Trust's written consent.

C. Cancellation

The Named Participant may cancel the Named Participant's Coverage Declaration in accordance with ORS 656.434(1)(b).

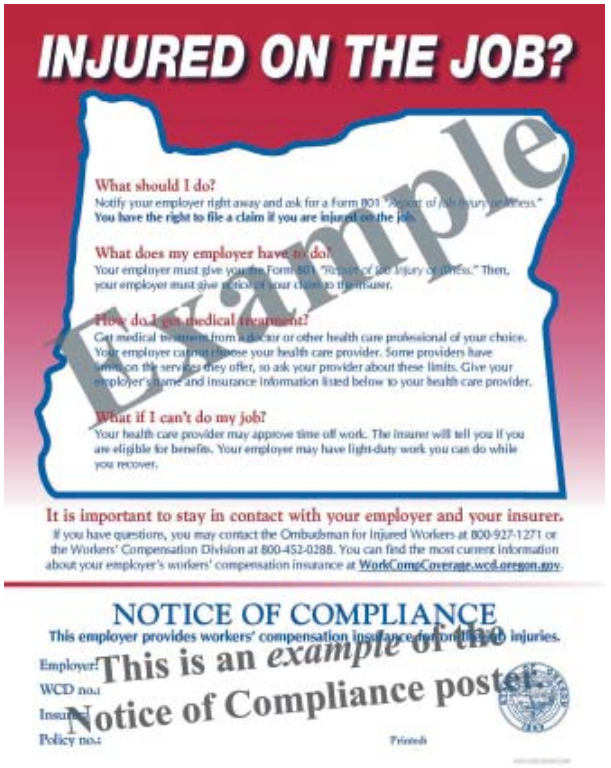
D. SEVERABILITY

To the extent reasonably possible, the terms, coverages, covenants and conditions set forth in this Coverage Document shall be construed in a manner that conforms to all applicable laws. If, however, any such provision is held to be invalid, illegal or unenforceable by reason of any statue, rule of law or public policy, then all of the other provisions of this Coverage Document shall remain in full force and effect, and this Coverage Document shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein. No provision of this Coverage Document shall be deemed to be dependent on any other provision unless expressly stated herein.

Notice of Compliance
Oregon Workers' Compensation REQUIRED POSTING Notice

All employers in Oregon who are required to provide workers' compensation coverage must display a Notice of Compliance poster in a central gathering area. Employers will automatically receive a Notice of Compliance poster when they first get compensation coverage or change coverage providers.

These notices are to be displayed conspicuously so workers know their employer is compliant with the workers' compensation law. Generally, employers are encouraged to have a posting notice in each building or area of their operations. A central gathering area, like a payroll distribution spot or central lunchroom, is a good choice for placement of the notice.



Each poster includes workers' compensation information to help workers and employers provide current insurance information to health care providers at the time of injury to speed up the claim process.

Notify your insurer of a worker's injury within five (5) days of your knowledge of a claim or accident that may result in a compensable injury. To look up employer coverage information, go online to: http://www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm.

If you *do not* have a Notice of Compliance poster, please call **503.947.7814**.

Order additional copies of the Notice of Compliance poster online at: http://www.cbs.state.or.us/wcd/operations/coverage/nocorder.html.

If you do not know if you are required to have a posting notice, please call the Employer Compliance Unit at **503.947.7815** or toll-free at **888.877.5670**.

A Spanish-language poster is available to supplement the English poster. Display the Spanish supplement next to the English poster.

Order additional copies of the Notice of Compliance poster online at

http://www.cbs.state.or.us/wcd/operations/coverage/nocorder.html

SDAO
SPECIAL DISTRICTS
ASSOCIATION OF OREGON

EMPLOYER OPTION FOR REIMBURSEMENT OF MEDICAL EXPENSES ON NONDISABLING CLAIMS

Employers may choose to reimburse SDAO for medical expenses up to the maximum amount* per non-disabling claim. (*See Maximum Medical Reimbursement Amount chart on back of this form.) Under this option, employers can totally eliminate or partially reduce claim costs from future consideration in determining experience modifications or other charges based on losses. **However, the reimbursement of claims is generally not recommended where the employer's annual premium is less than $5,000 since the reimbursed claim costs may exceed any premium savings.** The process works as follows:

1. **Prior to the start of each policy year, employers will be notified of their option to reimburse SDAO for medical expenses on accepted non-disabling claims.**
2. Employers who choose this option must complete, sign, and mail the election form to SDAO prior to the start of the policy year. **If you have previously made this election and you have had continuous coverage with SDAO, you need not make a new election.**
3. SDAO must receive the employer election form within thirty (30) days of the policy inception date to establish the employer as eligible for participation at the start of the policy. If the employer election form is received more than thirty (30) days after the policy inception date, participation in the program will be on a prospective basis, the first day of the next calendar quarter.
4. Enrollment in the program will continue until:
   a) An employer notifies SDAO in writing to cancel their participation, or
   b) An employer's coverage with SDAO is canceled.
5. To make the program effective, please carefully read the following. When a worker is injured it is important that an employer submit to SDAO a Report of Injury of Illness (Form 801) and Pain Diagram immediately upon learning of the injury. SDAO's claim adjusters will determine if the injury is compensable and will pay the related claim costs.

At the end of the policy year, SDAO will provide any employer who chooses this program with a billing for any reimbursable medical expenses for the maximum amount* each non-disabling claim. (*See the Maximum Medical Reimbursement Amount chart on the back of this form.)

An employer should not pay a medical provider directly as they may be paying for non-compensable injuries or services.

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

EMPLOYER ELECTION TO REIMBURSE SDAO FOR MEDICAL EXPENSES

If you are NOT INTERESTED IN OR ARE CURRENTLY A PARTICIPANT OF THIS PROGRAM**,** please discard this election form.

I elect to reimburse SDAO for up to the maximum amount* in medical expenses for each accepted non-disabling claim that I select. (*See the Maximum Medical Reimbursement Amount chart on the back of this form.) Please follow the reimbursement procedure on the reverse side of this form.

Effective: _____
(Month, Day, Year)

Complete District Name: _____

Signature of Authorized
Employer Representative: _____ Date: _____

Return completed form to **Special Districts Association of Oregon | PO Box 12613 | Salem, Oregon 97309-0613**

Employer Responsibility
Participation in the reimbursement program does not mean you can avoid filing a claim. You must still submit a completed Claim Report of Occupational Injury or Disease (Form 801) immediately upon learning of an injury. SDAO will continue to decide eligibility for benefits, audit medical bills and otherwise ensure that the claim is processed accurately and in a timely fashion.

Definition of a Non-disabling Claim
A non-disabling claim is one in which the injured person does not receive any payment from SDAO for time lost from work. These claims are considered minor in nature and the injured person returns to work within a few hours or days. Generally, time lost from work is less than three days. If non-disabling claim expenses exceeds the maximum amount*, you will only be billed up to the maximum*. (*See Maximum Medical Reimbursement Amount chart below.)

How to reimburse SDAO
At the end of the policy period you will receive a billing statement. You may choose to pay all, part or none of the billing by indicating the amount you wish to reimburse per claim on the billing statement. If you choose to reimburse SDAO, return a copy of the billing statement along with your payment within thirty (30) days of the billing date. Any payment received more than sixty (60) days after the billing date will not be accepted by SDAO and will be returned to you. In addition, you will lose your option to reimburse SDAO for the claim costs incurred during that statement period. However, your decision not to reimburse SDAO for any billing period will not terminate your reimbursement election.

Cancellation of Reimbursement Election
The reimbursement election will remain in effect until SDAO receives a written request from you to terminate your election or your coverage is canceled.

Retrospective Rating Plan
If you have a retrospective rating plan and are interested in this program, please contact your account representative for more information.

Background of Reimbursement Program
The 1987 Legislature enacted this law to help employers reduce or eliminate the claim costs considered when determining their future experience modification factors. At the time the employer reimburses SDAO, it is impossible to determine the effect the reimbursement will have on the experience modification factor. For more details see: Oregon Revised Statutes ORS 656.262, 656.307; Oregon Administrative Rule 436-060-0055.

If you have any questions, please contact your agent or your local account representative at the number listed below.

Special Districts Association of Oregon
PO Box 12613 | Salem, Oregon 97309-0613
Toll-free: 800-285-5461 | Phone: 503-371-8667
Fax: 503-371-4781
E-mail: sdao@sdao.com
Web Site: www.sdao.com

Maximum Medical Reimbursement Amount
See ORS 656.262(5) for a more complete description

Date of Injury	CPI-U Medical Care July 2008 Index %	CPI-Adjusted Base Amount, Prior to Rounding	**Maximum Medical Reimbursement Amount**
Prior to 1/1/06	N/A	N/A	**$ 500**
1/1/06 to 12/31/08	N/A	N/A	**$1,500**
1/1/09 to 12/31/09	0.03500	$1,552.50	**$1,600**

SDAO
SPECIAL DISTRICTS
ASSOCIATION OF OREGON

Sample

EMPLOYER OPTION FOR REIMBURSEMENT OF MEDICAL EXPENSES ON NONDISABLING CLAIMS

District Name

Your District previously enrolled in the optional Workers' Compensation Medical Expense Reimbursement Program. You may choose to pay all, part or none of the claims indicated below. Please indicate the amount you wish to pay per claim. Total the amounts you wish to pay per claim and remit the amount to SDAO at the address indicated below.

SDAO can't guarantee that the amounts paid by you will have a positive impact on your experience modification factor. Generally, the reimbursement of claims is not recommended if your District's annual premium is less than $5,000 since the reimbursed claim costs may exceed any premium savings.

For your reference we have attached a summary of how the program works.

You must respond within thirty (30) days to have the selected claims reduced or removed from your calculated experience modification factor.

Claim Number	Accident Date	Amount Paid	Amount You Elect to Reimburse SDAO	
WCSDA2005021563	4/5/2005	$ 208.19		*Maximum $500*
WCSDA2005021665	9/22/2005	$ 208.90		*Maximum $500*
WCSDA2005021823	11/27/2005	$1,925.96		*Maximum $500*
WCSDA2006022090	1/19/2006	$ 287.17		*Maximum $1,500*
WCSDA2007023707	3/28/2007	$4,266.59		*Maximum $1,500*
WCSDA2008026116	12/7/2008	$ 704.67		*Maximum $1,500*
WCSDA2009028986	1/2/2009	$1,185.09		*Maximum $1,600*
WCSDA2009022878	2/23/2009	$1,299.59		*Maximum $1,600*

Remit Payment to:
Special Districts Association of Oregon
PO Box 12613
Salem OR 97309
Phone: 800.285.5461 | Fax: 503.371.4781
Contact: Sandy Galaway

Completed by: _____

Date: _____

WHEN A WORKER IS INJURED ON THE JOB

1. Give the injured worker appropriate medical attention. If the accident is serious and/or the employee/volunteer is hospitalized, immediately call Special Districts Association of Oregon's Workers' Compensation Claims Office at 800. 305.1736.

2. Whether or not medical treatment is required, complete an **Incident Report** and **Pain Diagram**. Complete both forms for every injury, no matter how minor.

3. If the injured worker may need to go to the doctor or hospital, have the employee/volunteer **complete the Form 801** and **Pain Diagram** at once. If the worker is unable to complete the forms, complete the forms for them and have them sign the 801 form. Once signed it becomes a notice of claim and authorizes release of medical information. Complete the Employer's portion. Give the worker a copy and keep a copy for your records.

   Fax completed forms to SDAO at 503.620.6217. Mail originals to: Special Districts Insurance Services, PO Box 23879, Tigard OR 97281. Delaying sending the report can delay benefits.

4. If the worker requires medical treatment, give the worker a copy of the Workers' Compensation Division's ***A Guide for Workers Recently Hurt on the Job*** information page.

5. **Give the worker the Important Notice to Medical Provider form and the Release to Return to Work form to present to the doctor and/or hospital. Have the worker return the form and/or a note showing restrictions. Fax to SDAO at 503.620.6217 upon receipt.**

   If worker receives a full-duty release, employee/volunteer will return to their normal job. Fax a copy of the release to SDAO at 503.620.6217 upon receipt.

   If worker's Release to Return to Work indicates they require a light duty position, informally offer employee/volunteer a light duty job offer. Make sure worker is advised not to exceed job restrictions. If worker has concerns or denies offer, contact an SDAO Workers' Compensation Claims Examiner at 800.305.1736. Follow through with formal light duty offer letter, copy of doctor's note and a light duty job description.

   See if this claim qualifies for Employer-At-Injury funds. Contact SDAO at 800.305.1736 if you have questions.

6. If you feel that the claim is questionable, please give us a call or notify us on a separate sheet of paper attached to the 801 form.

7. When the employee/volunteer returns to work after a disabling injury, or if there is any change in the number of hours the employee/volunteer works, immediately call SDAO at 800.305.1736.

8. Reporting Fatalities and Hospitalizations to Oregon OSHA

   A. You must report the following to Oregon OSHA at 800.922.2689 or 503.378.3272 within the given time limits:
      1. Fatalities: 8 hours after occurrence or employer knowledge
      2. Catastrophe: 8 hours after occurrence or employer knowledge

      Note: You must report a fatality caused by a heart attack at work. The local OR-OSHA field office safety or health manager will decide whether to investigate the incident, depending on the circumstances of the heart attack.

   B. Report the following to the nearest Oregon OSHA field office (Portland, Salem, Bend, Eugene, or Medford).
      1. Overnight Hospitalization: 24 hours after occurrence or employer knowledge

      Note: Oregon OSHA Field Office locations, telephone, and fax numbers are listed on the back of this page.

If you have questions please call the SDAO Workers' Compensation office at 800.305.1736.

Oregon OSHA Field Offices

Salem Central Office
350 Winter Street NE, Room 430
Salem, OR 97301-3882
503.378.3272 / 800.922.2689
Fax: 503.947.7461

Portland
Fremont Place, Building I
1750 NW Naito Parkway, Suite 112
Portland, OR 97209-2533
503.229.5910
Fax: 503.229.6492

Salem
DAS Building, 1st Floor
1225 Ferry Street SE, Suite U110
Salem, OR 97301-4282
503.378.3274
Fax: 503.378.4921

Eugene
1140 Willagillespie, Suite 42
Eugene, OR 97401-2101
541.686.7562
Fax: 541.686.7933

Bend
Red Oaks Square
1230 NE Third Street, Suite A-115
Bend, OR 97701-4374
541.388.6066
Fax: 541.388.6203

Medford
1840 Barnett Road, Suite D
Medford, OR 97504-8250
541.776.6030
Fax: 541.776.6246

Pendleton
721 SE Third Street, Suite 306
Pendleton, OR 97801-3056
541.276.9175
Fax: 541.276.6869

Note: Overnight hospitalization if for medical treatment only. Hospitalization for observation is not reportable, nor is emergency room treatment. See the definitions section for "catastrophe."

Note: Do not report injuries (including fatalities) resulting from motor vehicle accident that happen on public streets, roads, or highways unless it is in a construction work zone.

Note: Report a fatality only if it occurs within 30 days of the accident.

Oregon
Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE, Room 27
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288, (503) 947-7810
TTY (503) 947-7993
www.wcd.oregon.gov

BULLETIN NO. 101 (Rev.)
February 14, 2007

TO: Workers' compensation insurers and self-insured employers

SUBJECT: Forms to be used in processing initial claims of occupational injury or disease

This bulletin provides or describes forms that meet the requirements of ORS 656.265, OAR 436-060-0010, and OAR 436-060-0015:

- **Form 440-801, "Report of Job Injury or Illness"**
- **Form 440-3283, "A Guide for Workers Recently Hurt on the Job"**
- **Form 440-1138, "What happens if I'm hurt on the job?"**

Form 3283 has been revised. Forms 801 and 1138 have not been revised. This bulletin replaces Bulletin No. 101 (Rev.) dated August 4, 2004. Form 801 claim filing requirements are described in OAR 436-060-0010.

I. Printing and distribution of "Report of Job Injury or Illness," Form 801

A. Employers must provide Form 801 to injured workers (or anyone acting on their behalf) upon request.

B. On all reporting forms, print the name, address, and phone number of the insurer, self-insured employer, and service company, if any.

Note: Some of the information on the 801 (and the Federal Form 301) is subject to release by the employer to authorized employee representatives upon request. Information must be made available in such a way that confidentiality of the claimant is protected regardless of the form used.

II. The information page, "A Guide for Workers Recently Hurt on the Job," Form 3283

This form has been revised. Insurers must provide Form 3283 to their insureds for distribution to workers at the time workers complete Form 801. An insurer may also include its name and phone number in the heading, at the end of the 3283, or in the paragraph "What if I have questions about my claim?" To ensure distribution of Form 3283, the division recommends it be printed on the back of Form 801. Insurers may use up their supplies of 801 forms and incorporate the new Form 3283 when it is necessary to restock. For insurers and employers that rely on electronic forms for "on-demand" printing, electronic copies of Form 3283 (and all workers' compensation forms) are available at: http://wcd.oregon.gov/policy/bulletins/forms.html.

III. The pamphlet, "What happens if I am hurt on the job?," Form 1138

The insurer must provide the pamphlet (Form 1138) to every injured worker who has a disabling injury or disease claim with the first time-loss check or earliest written correspondence. **Distribution of Form 1138 for a nondisabling claim is not required unless requested by the worker.** The division will furnish Form 1138 to insurers upon request, limited to a four-month supply. Contact the division at (503) 947-7627 to request copies of the pamphlet.

If you have questions about this bulletin, a Benefit Consultant may be reached at (503) 947-7585. To obtain high quality originals of Forms 801 or 3283, contact the Workers' Compensation Division at (503) 947-7627, or download forms at www.wcd.oregon.gov**.**

/s/ Jerry Managhan for
John L. Shilts, Administrator
Workers' Compensation Division

Attachments: Forms 440-801 (Rev. 8/04); 440-3283 (Rev. 1/07)

Distribution: WCD-ID, S0, S1, S, T, U, PT, LY

Incident Report

Worker

Name of Employee/Volunteer: _____ Gender: [ ] Male [ ] Female

Job Title: _____

Employer: _____

Date of Incident: _____ Time of Incident: _____ [ ] am [ ] pm

Incident Location: _____

Reported to: _____ Phone: _____ Staff: [ ] Yes [ ] No

Witnesses: _____ Phone: _____ Staff: [ ] Yes [ ] No

Witnesses: _____ Phone: _____ Staff: [ ] Yes [ ] No

First Aid Given? [ ] Yes [ ] No If yes, please indicate the type of first aid:

[ ] Ice [ ] Washed Wound [ ] Kept Immobile [ ] Stopped Bleeding

[ ] Observed [ ] Applied Splint [ ] Applied Dressing [ ] Other

Do you require medical treatment beyond first aid? [ ] Yes [ ] No **If yes, please complete form 801.**

Body Part Injured*: Using **L** for Left and **R** for Right, indicate your injuries below

L = Left
R = Right

HEAD	TRUNK	EXTREMITIES		OTHER
__ Ear	__ Abdomen	__ Ankle	__ Lower Arm	__ _____
__ Eye	__ Back	__ Elbow	__ Lower Leg	__ _____
__ Face	__ Chest	__ Finger	__ Thumb	__ _____
__ Head	__ Groin	__ Foot	__ Toes	__ _____
__ Neck	__ Shoulder	__ Hand	__ Upper Arm	__ _____
__ Scalp	__ Trunk	__ Knee	__ Wrist	__ _____

***Also complete attached Pain Diagram.**

Type of Injury Suspected:

[ ] Laceration/Abrasion [ ] Bruise/Contusion [ ] Sprain/Strain

[ ] Dislocation [ ] Fracture [ ] Concussion

[ ] Surface Cut/Scratch [ ] Burn

[ ] Other: _____

Describe how incident occurred, including events that occurred immediately before the accident: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Employee/Volunteer Name: _____

Employee Signature: _____ Date: _____

Supervisor

Date Reported: _____ Time: _____ [ ] am [ ] pm To Whom? _____

Were other workers injured? [ ] Yes [ ] No If yes, please name: _____

Additional Comments: _____

_____

_____

I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.

Print Supervisor Name: _____

Supervisor Signature: _____ Date: _____

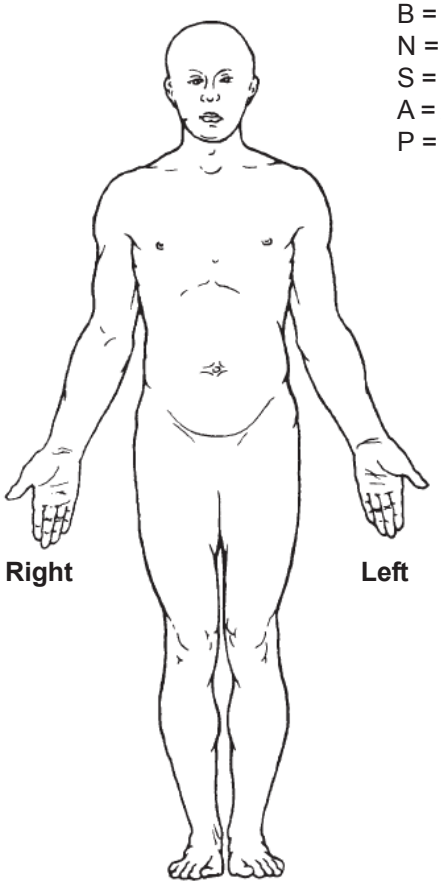
Pain Diagram

This Pain Diagram needs to completed and submitted with either an **Incident Report**, an **801 Form**, or both. Mail originals to SDAO, PO Box 23879, Tigard OR 97281. Please retain a copy for your own records.

Name:_____ Employer:_____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

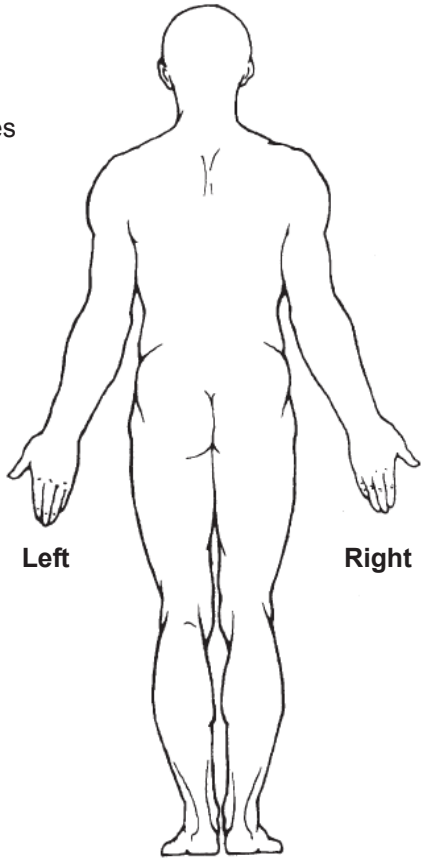
Front



Right **Left**

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Left **Right**

	0 = No Pain			**Pain Scale**						*10 = Severe Pain*
Circle one:	0	1	2	3	4	5	6	7	8	9	10

Please use the space below to describe your condition further, if needed: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: _____

Worker's Signature: _____ Date: _____

Special Districts Association of Oregon | PO Box 23879 | Tigard OR 97281
Phone: 503.670.7066 | Toll-free: 800.305.1736 | Fax: 503.620.6217

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.
- 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.
- 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.**

440-3283 (1/07/DCBS/WCD/WEB)

SDIS – SELF-INSURED EMPLOYERS GROUP
P.O. Box 23879
Tigard, OR 97281-3879
(503) 670-7066 / 1-800-305-1736
Fax (503) 620-6217

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 / Part
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)				Ev / Src / 2src
Name of Witnesses:	Have you previously injured or sought treatment for this body part? ☐Yes ☐No			

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: / Dept. & Job Title:	Work phone:	
Name of your primary care physician:	If medical treatment was not with your primary care physician, 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. I authorize the release of 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. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

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:
Workers shift on day of injury: (from) _____ ☐ a.m ☐ p.m. (to) _____ ☐ a.m ☐ p.m.		
Worker's weekly wage: Per ☐ Hr. ☐ Day ☐ Wk. ☐ Mo ☐ Yr $_____	Give total weekly wage and explain if wage prior to injury varied or included other earnings (tips, room and board, commission, etc.) Attach 52 weeks of payroll records.	
Return-to-work status ☐ Not returned ☐ Regular Date: ☐ Modified Date:	If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No	
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		NCCI code:
Were other workers injured? ☐Yes ☐No	OSHA 300 log case #:	

Date employer knew of claim:	Person claim reported to:	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) 3789-3272, or Oregon Emergency response (800) 452-0311, on nights and weekends.

801

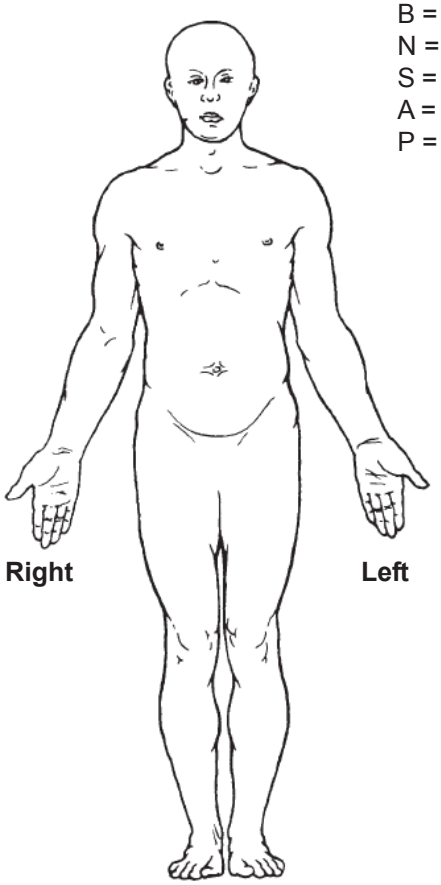
Pain Diagram

This Pain Diagram needs to completed and submitted with either an **Incident Report**, an **801 Form**, or both. Mail originals to SDAO, PO Box 23879, Tigard OR 97281. Please retain a copy for your own records.

Name:_____ Employer:_____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

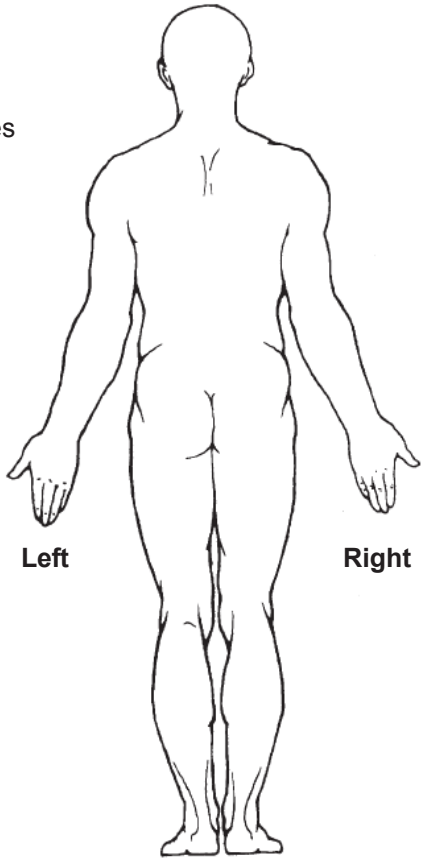
Front



Right **Left**

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Left **Right**

	0 = No Pain			**Pain Scale**							*10 = Severe Pain*
Circle one:	0	1	2	3	4	5	6	7	8	9	10

Please use the space below to describe your condition further, if needed: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: _____

Worker's Signature: _____ Date: _____

IMPORTANT NOTICE TO MEDICAL PROVIDER

This is to advise that all Workers' Compensation Department forms, bills, etc. for services and other matters related to occupational injuries and diseases involving employees of:

_____

District Name

are to be sent to:

SDAO Claims Office

PO Box 23879

Tigard, Oregon 97281

Fax: 503.620.6217

Toll-free: 800.305.1736

Phone: 503.670.7066

Return form to:

RELEASE TO RETURN TO WORK

Name of worker	Claim number

Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? ☐ Yes ☐ No If yes, date: _____ (Provide closing information and complete Form 827.)

   If no, estimated medically stationary date: _____ Are there permanent restrictions? ☐ Yes ☐ No ☐ Unknown

   Next scheduled appointment date: _____

2. Worker is released to:

   ☐ full duty without limitations Date: _____ (Do not complete lines 3 through 11. Sign below.)

   ☐ modified duty from (date): _____ through (date): _____ (specify limitations below)

   ☐ modified hours specify hours: _____ from (date): _____ through (date): _____

   ☐ not released to work Est. RTW date: _____ If modified release, provide date of anticipated regular release: _____

	Hours:	**No limitations**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Other (specify)**
3. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can stand/walk a total of		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
4. At one time, worker can stand/walk		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
5. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can sit a total of		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
6. At one time, worker can sit		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	**<10**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**>100**
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:

	Right	**Left**	
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No	Dominant hand
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No	
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:

	Continuous 67-100% of the day	**Frequently 34-66% of the day**	**Occasionally 6-33% of the day**	**Intermittently 1-5% of the day**	**Not at all**
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Climb	☐	☐	☐	☐	☐
g. Balance	☐	☐	☐	☐	☐
h. Reach	☐	☐	☐	☐	☐
i. Push/pull	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

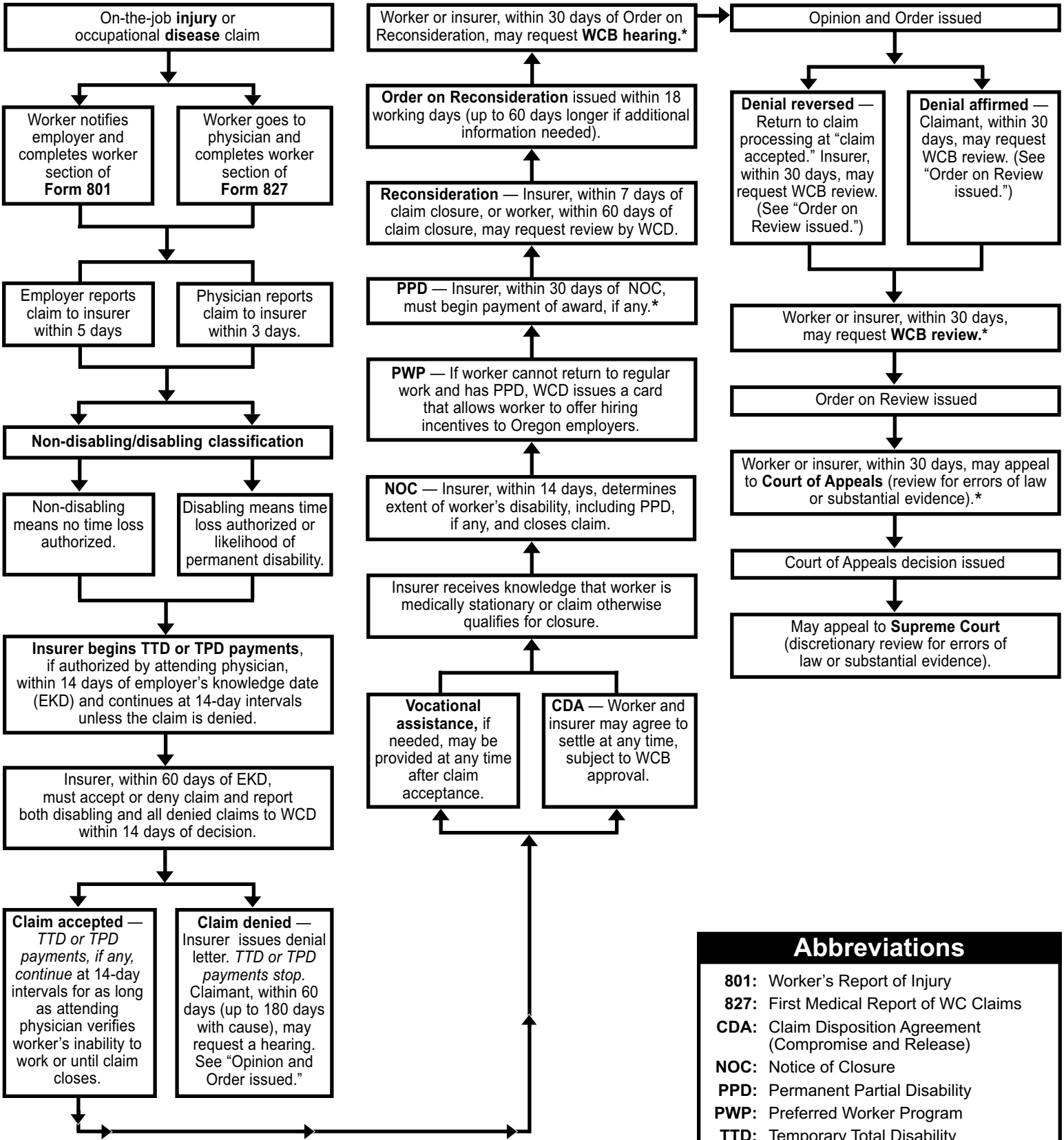
Signature of medical service provider*	Printed name	Date

440-3245 (10/05/DCBS/WCD/WEB)

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.

Workers' Compensation Flowchart

(This is an overview. Some programs and processes are not covered.)



Abbreviations

801:	Worker's Report of Injury
827:	First Medical Report of WC Claims
CDA:	Claim Disposition Agreement (Compromise and Release)
NOC:	Notice of Closure
PPD:	Permanent Partial Disability
PWP:	Preferred Worker Program
TTD:	Temporary Total Disability
TPD:	Temporary Partial Disability
WCB:	Workers' Compensation Board
WCD:	Workers' Compensation Division

* Some compensation is stayed (not paid) during appeal (see ORS 656.313)

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
www.wcd.oregon.gov

440-2235 (5/04/COM)

Instructions for accessing 801's online at http://www.sdao.com

First Time Users

- Go to http://www.sdao.com
- Place your cursor over "Register" until the drop-down menu appears
- Click "SDAO Member Site"
- If you are an insurance agent click Agent followed by the "Continue" button.

  If you are an SDAO Member, click Member followed by the "Continue" button.
- Using the pull-down menu, select your district's name and click "Continue"
- Complete the SDAO Member Site Registration Form. Record your ID number and password for future reference
- When finished click "Submit"
- After you receive an e-mail confirming your account activation, follow the "Already Registered" steps to access the 801 form online.

Already registered? Start here

- Go to http://www.sdao.com
- Click the "Member Login" link
- Type your "ID Number" and "Password" and click the "Login" button
- Select the "Insurance" tab
- Click the "Workers' Comp." link (left side of page)
- In the Workers' Compensation 801 Form section, click the "801 - PDF Version" link
- Print and/or save the file

Memorandum

To: SDAO Members

From: Toni Martin, WC Senior Claims Examiner

Subject: Benefits

If you are injured and work more than one job, you may be entitled to additional benefits.

Oregon workers injured on the job in 2002 or after may be eligible for supplemental benefits if they had (or have) more than on job at the time of injury thanks to Senate Bill 485.

This workers' compensation law changed how benefits are calculated. Benefits for qualified workers will be calculated using the combined earnings of the job where the injury occurred and other employment held at the time of the injury, resulting in increased benefits to the injured worker.

To qualify, workers employed at more than one job, injured in 2002 or later, must notify their workers' compensation insurer of their other job(s). Then, within thirty (30) days from the time the insurer receives the claim, the injured worker must provide proof of multiple employment and the legal name(s) of the other employer(s). Such proof should be paycheck stubs or payroll records from the employer(s). The additional employment must be subject to Oregon workers' compensation laws.

Under the new law, injured workers who receive benefits must provide ongoing documentation to continue to receive those benefits for time lost at other employment, even in the worker is not missing time from the job where the injury occurred.

For more information about the benefit call SDAO's Claims Office at 800.305.1736.

Oregon
Theodore R. Kulongoski, Governor

Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
PO Box 14480
Salem, OR 97309-0405
1-800-452-0288, (503) 947-7810
TTY (503) 947-7993
www.wcd.oregon.gov

BULLETIN NO. 325 (Revised)
January 14, 2005

TO: Workers' compensation insurers, self-insured employers, and other interested parties

SUBJECT: Supplemental disability payment and reimbursement

EFFECTIVE: Immediately

The purpose of this bulletin is to provide forms and formats for supplemental disability processing and reimbursement under OAR 436-060-0035 and 0500 and an amended Form 3530, "Supplemental Disability Election Notification." Form 3530 has been amended to eliminate the year designation with regards to how long the assigned processing agent is elected to process supplemental disability claims. This bulletin supersedes Bulletin 325 issued January 28, 2004. No other substantive changes have been made to the bulletin. All forms listed in the bulletin may be downloaded from the Workers' Compensation Division's Web site: http://wcd.oregon.gov/policy/bulletins/ab_index.html.

I. Form 3530, "Supplemental Disability Election Notification." Under OAR 436-060-0010(20), if you elect not to process and pay supplemental disability benefits, file Form 3530 with the director. The election remains in effect until you change it.

II. Form 3531, "Physician Authorization of Supplemental Disability." This form is for the insurer or the assigned processing agent to send to the worker. Under OAR 436-060-0035, the worker has on-going responsibility to provide information and documentation to the insurer or the assigned processing agent who is processing supplemental disability.

III. Supplemental disability payment by insurer or self-insured employer and reimbursement of costs from the Workers' Benefit Fund. If the insurer elects to pay supplemental disability, payment (if appropriate) must be made within 14 days of the insurer's receipt of verifiable documentation from the worker. The division will reimburse the insurer's costs from the Workers' Benefit Fund in accordance with OAR 436-060-0500. A completed Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," provides the information required to process the reimbursement. Insurers may develop their own forms or spreadsheets for requesting reimbursement provided such forms include the same data elements, to include the legal names of additional employers and each employer's WCD registration number. (See Section IV of this bulletin for information on how to obtain this registration number.)

Under this election, in addition to the supplemental disability reimbursement, the division will calculate and include in the reimbursement an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

Reimbursement requests must be submitted no later than 30 days after the end of each calendar quarter to be included in that quarter's reimbursement. Otherwise, requests will be held over until the next quarter's reimbursement.

IV. How to find the WCD employer registration number:

- **Phone the employer index, (503) 947-7814**
- **Fax requests to: (503) 947-7718**
- **E-mail requests to: wcd.employerinfo@state.or.us**

Look up information on WCD's Web site:
www.wcd.oregon.gov/compliance/ecu/empcoverage.html

V. How to calculate supplemental disability benefits:

Supplemental disability is only available for injury dates on or after January 1, 2002.

Determine weekly wage according to ORS 656.210 and OAR 436-060-0025 for each employer.

Multiply wages from primary employer by 66 2/3 (.6667) to calculate the temporary disability rate based solely on those wages. If results meet or exceed the maximum temporary disability rate (133% of Oregon average weekly wage), the worker is not eligible for any supplemental disability benefits.

Combined benefit paid to the worker:
If primary employer wages do not meet or exceed the maximum rate, combine the determined weekly wages from each employer and multiply by .6667 to calculate the combined temporary disability rate up to the maximum rate. To calculate temporary partial disability, use all post injury wages for primary and secondary employers.

Supplemental disability reimbursed through Workers' Benefit Fund:
First calculate the temporary disability benefit payable based solely on primary employer wage at injury and primary employer post injury wages. Then subtract those results from the combined benefit paid to the worker; the difference is the supplemental disability and is reimbursed through the Workers' Benefit Fund.

NOTE: Insurers are encouraged to download free temporary/supplemental disability calculation software from WCD's Web site:

http://www.cbs.state.or.us/external/wcd/policy/bulletins/ptd_software.html

Please address questions regarding supplemental disability benefits or calculations to a Benefit Consultant, (503) 947-7585. If you have questions regarding reimbursements from the Workers' Benefit Fund, call (503) 947-7810 and ask for a Reimbursement Program Specialist.

/s/ John L. Shilts
John L. Shilts, Administrator
Workers' Compensation Division

Distribution: WCD-ID, S0, S1, LY

Attachments: Form 440-3530, "Supplemental Disability Election Notification" (Rev. 1/05)
Form 440-3531, "Physician Authorization of Supplemental Disability" (Rev. 9/03)
Form 440-3504, "Supplemental Disability Benefits Quarterly Reimbursement Request" (Rev. 8/02)

OREGON
DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

PHYSICIAN AUTHORIZATION OF SUPPLEMENTAL DISABILITY

Worker: You are responsible for getting this form completed by your physician to continue receiving supplemental disability.

Worker

Worker name _____ Date of birth _____

Date of injury _____ Claim number _____ Primary insurer _____

Definitions:

- **Primary job** means the job at which the injury occurred.
- **Secondary job** means any other job held by the worker at the time of injury.
- **Temporary disability** means wage loss replacement for the primary job.
- **Supplemental disability** means wage loss replacement for the secondary job(s) that exceeds the temporary disability.

Physician

Physician's name (printed) _____ Phone number _____

Address _____ City _____ State _____ ZIP _____

Medically stationary?
☐ Yes (date): _____
☐ No (anticipated date): _____

Worker/patient ability to work:
☐ Regular work authorized start (date): _____
☐ Modified work authorized from (date): _____ through (date, if known): _____
☐ No work authorized from (date): _____ through (date, if known): _____

Restrictions:

I certify that these restrictions apply to :
☐ **Primary job**
☐ **Secondary job**

Physician's signature _____ Date _____

440-3531 (9/03/DCBS/WCD/WEB)

Injury Reporting and Medical Treatment Policy

District Name: _____

1. **All on-the-job injuries shall be reported.**

2. All Oregon state laws concerning Workers' Compensation shall apply.

3. Injuries shall be reported immediately to the employer or employer representative when employee becomes aware he/she has suffered an on-the-job injury.

4. When a Supervisor's injury report is filled out, the employee will be given a Return to Work Recommendations Form. If the injury requires medical attention, the employee is to take the Return to Work Recommendations Form to the doctor and return it to their supervisor at the beginning of their next scheduled shift If you cannot locate your supervisor, contact the Workers' Compensation Manager

   Name of Workers' Compensation Manager:_____

   Phone Number/Contact Information: _____

5. If you cannot contact or be seen by your family physician, we suggest that, on weekdays between the hours of 7:30 am and 4:00 pm, that you use the medical provider at the location.

6. Notify the doctor that the company does have modified duty positions available and will make every effort to return you to work as soon as possible and within the doctors prescribed limitations.

   A. If modified work is ordered by the doctor, the restrictions must be clearly stated and for what period of time.

   B. When you are ready to return to work, you must have a doctor's written release.

   C. If time off is ordered, you must bring a statement from the doctor stating the period of time you will be off work.

7. It shall be the employee's responsibility to notify the District of any change in the status of the industrial injury.

Advantages of the Return to Work Program

- The district receives some productivity for the money it would otherwise spend for time loss.
- The district saves on the claim cost for time loss.
- The employee/volunteer remains a contributing member of the community.
- By returning the injured employee/volunteer to work we remove incentives to being unnecessarily disabled.
- No free “time to kill.”
- Does not become apathetic to work.
- Not eligible for other disability programs which would make returning to work undesirable.
- Healing is better and faster.
- Injured muscles do not continue to weaken from complete inactivity.
- Other muscles do not weaken.
- Employee/volunteer does not get trapped in legal drug habit.
- Employee/volunteer does not have to worry about having a job after he/she has healed.
- Fewer cases end up in litigation.
- District maintains contact with injured employee/volunteer.
- If employee/volunteer refuses to cooperate in his/her rehabilitation they can lose their benefits.
- Lowers the district’s experience modifier.
- Employee/volunteer continues to operate within sphere of peer group.
- Wage Reimbursement

Accomplishing an Earlier Return to Work Climate

Studies have shown that the longer an injured worker stays away from work the greater the likelihood for permanent disability and increased workers' compensation costs. The Return to Work Program is designed to assist you in creating light or modified jobs for your injured workers, thereby allowing them to return to work as soon as possible and keep claim costs at a minimum.

Additionally, the State of Oregon provides financial incentives to employers who return employees to temporary light duty or permanent modified work.

Commitment

For the program to be successful, you as the employer, need to make some commitments.

You need to establish an early contact program with your injured employees. Early contact is very important. It is suggested that employees be contacted by their supervisor immediately after their first exam when suspective of a lost time injury. Supervisors should show concern for the employee at this time. Without early contact your injured worker may become worried about his or her future employment. Lack of communication in this area may lead to an adversarial relationship which may in turn lead to prolonged disability and increased claim costs.

Allow our staff to assist you in creating light or modified jobs. Many employers are not aware of the potential for light or modified jobs within their company. They are also not aware of the direct impact on claims costs and premium levels that using a Return to Work Program can have. For example, if you put an injured worker back to work full-time on a modified job at the pre-injury wage, temporary total disability (time loss) payments cease.

Long periods of time loss not only adversely affects future premium costs, but can also affect future premium levels through increased experience modifiers. By including a Return to Work Program in a comprehensive claims management program, employers are able to positively influence their overall loss experience.

Getting Started

The first step in implementing your Return to Work Program is to secure the support of supervisors and managers by educating them on the need for and advantages of such a program. These are the people who will run the program and they need to understand the concept. Supervisors should be made accountable to management whenever possible for the workers' compensation costs attributed to their department.

The next step is to designate someone in your organization as return to work coordinator. It will be their responsibility to make necessary contacts and monitor the recovery process on a continuing basis. To maximize effectiveness, this individual must be made accountable to top management for results; getting injured employees back to work.

A third step is the development of a written policy and set of procedures which outlines the company's light and/or modified work program. This statement should be made a part of the company's policy governing the reporting of injuries. Every employee should know the employer will help with returning an employee to work.

You may augment this policy by forming a committee for developing light duty options. Many districts may want to use an already established Safety Committee for this purpose. To assist in measuring effectiveness, be sure to solicit feedback from all classifications of employees.

Advertise

Once you have established your program advertise it! When an employee is injured, notify him or her that you have a light duty program. Send a letter to the treating physician. Make the physician aware of your concern for the worker and ask for physical limits as soon as possible. To build physician rapport, consider plan tours or send a company representative to explain your programs. If at all possible, we recommend you establish a treatment program with a local physician and make this known to all employees.

Your insurance carrier can contract with a Managed Care Organization to provide medical services to your workers for their compensable workers' compensation claims. With such a contract, the only exception is emergency medical treatment.

Although injured employees have freedom of choice as to treating physician, an arrangement with a local physician will insure prompt medical treatment. Our experience has been that most employees will not object to being treated by a company-recommended physician.

Employers who have implemented Return to Work Programs are experiencing substantial reduction in premium and improved employee morale. SDAO wants you to benefit (by allowing us to assist you) in establishing and maintaining such a program within your company.

Employment Reinstatement Rights (See ORS 659A.043 through 659A.052)

Duty to Reinstate Injured Worker is protected by law. Employers of more than twenty (20) workers must reinstate an injured worker to the job held at injury, even if the position has been filled, unless that job has been eliminated or the worker is disabled from performing it. If the job is not available, the worker must be restored to any other existing job that is available and vacant.

The reinstatement duty does not apply to:

1. Workers hired temporarily to replace an injured worker.
2. Seasonal workers employed to work less than six (6) months in a calendar year.
3. Union workers from a hiring hall operating pursuant to a collective bargaining agreement.
4. Workers whose employer employs less than twenty (20) persons at the time of injury and at the time of reinstatement.

The duty to reinstate the former position terminates when the worker (See ORS 659-430):

1. The worker is deemed unable to return to his job at injury by either his attending physician or a medical arbiter.
2. Is eligible for and participates in vocational rehabilitation.
3. Accepts suitable employment elsewhere after becoming medically stationary.
4. Refuses a bona fide offer of suitable modified work from the employer before becoming medically stationary.
5. Fails to request reinstatement within seven (7) days of notification by certified mail of release to work.
6. Three (3) years elapse from the date of injury.

Job Site Modification

If an employee is unable to return to their regular job, either temporarily or permanently, because of physical limitations resulting from an injury, job site modification assistance is available. The Workers' Compensation Department administers a program providing financial assistance to aid in the return to work of injured employees. Please refer to the Reemployment Assistance Program sheet attached.

If interested, contact your claims examiner who will arrange for one of our specialists to assist you.

Assistance Available

If we can assist with identifying light duty tasks, writing up job descriptions, preparing video tapes, please contact your Account Manager. If appropriate, our staff (with assistance from your Third Party Administrator) can also assist you in submitting applications with the Workers' Compensation Department for job site modification or wage subsidy funds from the Reemployment Reserve Funds.

The following pages contain sample procedures, forms, and letters for a Return to Work Program. Please take the time to become familiar with each sample.

Implementation Steps for the Return to Work Program

Contact the injured worker the day after his/her injury if he/she does not return to work. Ask the following questions:

1. What is the nature of your injury?

   This tells you the type of light duty your employee will require.

2. How long does the doctor think you'll be off work?

   If injured worker states only a few days then you will not pursue light duty.

3. Who is your physician?

   This tells you the name of the physician to write the light duty request.

4. When will you see your doctor again?

   This information lets you know how soon you should have the light duty request in the physician's office.

After obtaining the above information and discerning that the injured worker is a candidate for light duty, proceed with the following:

1. Write a job description within claimant's physical limitations and send a light duty request letter to treating physician.

2. If the doctor does not contact you either verbally or by fax call his/her office and ask to speak to the insurance secretary.

   Ask:

   a. If the doctor has made a determination on whether or not the injured worker is able to return to light duty.

   b. If the doctor has not released injured worker when does he/she anticipate doing so.

3. If you obtain doctor's written or verbal authorization, send letter to injured worker by certified mail.

Points to Remember

When implementing your Return to Work Program, keep these points in mind:

- Get started now! Don't wait for a claim to occur.
- Begin by surveying all jobs within your facility. Due to ADA requirements, you may have already identified "Essential Job Functions" for each position. Identify which of these functions can be temporarily modified for light duty and identify the type of light duty they can accommodate i.e.: one-handed work, or no lifting over 20 pounds.
- Keep a list of the light duty tasks identified. Keep in mind that many tasks compose a job. Quantify them in terms of time spent in each task. You will use this list later to define your light duty jobs.
- Get assistance from all available sources. Talk to other employers with a similar work force.
- Compose job descriptions from your list of light duty tasks. Maintain a file.
- Be prepared to substitute alternate light duty tasks if the physician rejects all or some of the light duty tasks on an original plan. Think of light duty jobs in terms of modular components, i.e., if tasks A&B aren't suitable maybe tasks C&D are suitable.
- Involve any appropriate unions in the development of the Return to Work Program. Emphasize the jobs as being temporary. Remind unions that only working employees can pay dues.
- Video tape or photograph light duty tasks if possible. A picture is worth a thousand words - even with physicians.
- If possible, put workers into light duty positions within their own department.
- Make light duty jobs a "viable position", but keep the assignment meaningful. Have the worker perform work that needs to be done but keep in mind that the idea is to encourage the worker to ask for a release to regular work.
- Communicate early and frequently with the employee and the physician. Make the employee responsible for periodic contact, but have supervisors also initiate contact. Show concern!
- Make all job offers in writing. Include the time and place the employee is to report for work and provide a description of duties that the physician has approved. Create flexibility in job offers by ending the job description with a statement such as, "Any other work assignment which does not exceed your physician's restrictions." Make sure your job offer letter shows the date the light duty expires. This may help avoid temporary work becoming permanent due to ADA litigation.
- Keep good records. Formulate a return to work record. Make your return to work coordinator and your supervisors responsible for completing these records.
- Have the employees sign off on job offers and make them aware that they are subject to normal disciplinary procedures.

Sample

Early Return to Work Program

District Name:_____

Policy

Our district has developed an Early Return to Work Program for workers to return to temporary light duty when a work-related injury or illness prevents those individuals from returning to their regular job. Light duty tasks for injured employees with accepted disabling injuries have been identified.

The temporary light duty program has been designed to aid in returning injured workers to the work force as soon as possible after their injury. The intent is to place the injured worker in temporary light duty that can be performed within their physical restrictions and/or reduced work hours.

While working under this program, injured workers will retain their hourly rate of pay in effect at the time of injury or illness. In most instances a temporary light duty work assignment will not change a worker's benefit coverage and premium amounts.

Definitions

1. **Injured Worker**

   A worker who has suffered a job-related injury or illness which results in an accepted compensable claim.

2. **Workers' Compensation Coordinator**

   The designated company representative who is responsible for the management of the workers' compensation program for our district. The role of the Workers' Compensation Manager is to facilitate a systematic response to workers' compensation problems. The Workers' Compensation Manager serves to analyze situations that develop and meet the needs of everyone involved.

3. **Light Duty**

   Temporary job tasks which the injured worker can perform while recovering from the illness or injury. The job tasks are adapted to comply with the Return to Work Recommendations Form completed by the treating physician. These job assignments are normally limited to thirty (30) calendar days and will be evaluated on a case-by-case basis at that time.

Forms

1. **Injury Reporting & Medical Treatment Policy**
   An outline of the injured employee's reporting responsibilities.
2. **Incident Report**
   Completed by the Supervisor following every accident to assist in safety follow-up and prevention of future accidents.
3. **Return to Work Recommendations Form**
   To be completed by the physician listing the treatment plan, release for specified work and physical capacities evaluation.
4. **Temporary Light Duty Offer**
   A notice of temporary light duty including a written description of the temporary light duty work assignment, the re-employment start date, time, hours, wages and the supervisor. This is to be signed by the employee, supervisor, and attending physician.
   A. Notifies the attending physician of the physical tasks to be performed by the injured worker.
   B. Notifies the attending physician of the location of the modified work offer; and

C. Asks the attending physician if the worker can, as a result of the compensable injury, physically commute to and perform the job.

D. The attending physician agrees the employment appears to be within the worker's capabilities and the commute is within the physical capacity of the worker; and

E. The employer or insurer has confirmed the offer of employment in writing to the worker stating:

1) The beginning time, date, and place;

2) The duration of the job, if known;

3) The wages;

4) An accurate description of the physical requirements of the job;

5) That the attending physician has found the job to be within the worker's capabilities and the commute within the worker's physical capacity

F. If complications or questions arise during the return to work process contact your claims examiner.

Injury Reporting Procedures

1. Employees will report all injuries immediately to their supervisor. In any event, all injuries must be reposted no later than the end of the shift in which the injury occurred.
2. All injured employees must obtain a Return to Work Recommendations Form from their supervisor before seeking medical attention. The Return to Work Recommendations Form, completed by the doctor, must be returned to the supervisor immediately following medical treatment. The employee must complete a claim form. If a supervisor cannot be located, contact the Workers' Compensation Manager at the facility.
3. It is the employee's responsibility to inform the doctor that the company does not have modified duty positions available and will make every effort to return them to work as soon as possible and within the doctor's prescribed limitation.
   A. If modified work is ordered by the doctor, the restrictions must be clearly stated and for what period of time.
   B. When the employee returns to work, they MUST have a doctor's written release.
   C. If time off is ordered, a written statement from the doctor stating the period of time the employee will be off is required.
4. Employee must report any change in condition to the supervisor and arrange to see the physician if unable to work due to increase in symptoms.
5. After every doctor's visit, the injured worker's medical status is to be reported in writing to the supervisor.
6. Every effort should be made to schedule doctor appointments outside work hours. Time away from work for physician, physical therapy, or other appointments related to illness or injury generally is unpaid.
7. If unable to work, employee is to maintain weekly contact with the supervisor.
8. The worker is expected to follow the same performance standards as a regular worker. This includes satisfactory completion of work assignments, reporting to work on time, completing scheduled shifts and arranging for time away from work with the supervisor.

In the event the Physician does not release the employee to full duty:

1. Supervisor is to immediately contact the Workers' Compensation Manager and determine the light work to be provided for the injured worker.
2. Supervisor completes and has employee sign the Temporary Light Duty Offer.

3. Supervisory Injury Report, Return to Work Recommendations From, Temporary Light Duty Offer, and report of injury claim form are to immediately be provided to the Workers' Compensation Manager.

Employer Responsibilities

Supervisors

1. Supervisor directs the injured worker to a physician upon report of injury and supplies the injured worker with a Return to Work Recommendations Form.
2. Meets with injured worker to review status of injured worker and parameter of physician's light duty activity prescription (see attachment).
3. Orients injured worker to a temporary light duty job. Communicates clear understanding of expectations.
4. Monitors worker's performance, which includes working within expected parameters of light duty activity prescription, attendance, quality, and quantity of work assigned.
5. Supervisor completes required forms (see Workers' Compensation Manager) and forwards them to the Workers' Compensation Manager for processing.
6. Notifies Workers' Compensation Manager of any problems that arise, such as workers' inability to perform assigned tasks, absenteeism, or other performance problems.
7. The Supervisors are responsible for identifying several tasks within their departments that can be utilized for light duty work. These will be developed in coordination with the Workers' Compensation Manager and Safety Coordinator.

Workers' Compensation Coordinator

1. Is contacted by the supervisor in the event an injured worker is unable to return to regular duty. The Workers' Compensation Manager in conjunction with the Safety Coordinator will assist the supervisor in designing and assigning light duty tasks.
2. Workers' Compensation Manager shall receive the Supervisor Injury Report, Return to Work Recommendations Form (any documentation from physician), the Light Duty Work Offer, and the Workers' Compensation claim form from the Supervisor in order to process reports.
3. Completes and sends the claim for to the Workers' Compensation insurance company. Notifies Workers' Compensation insurance company of injured worker's return to temporary light duty, scheduled hours, rate of pay and any significant changes in work status.
4. Notifies Workers' Compensation insurance company when the injured worker is able to return to full work duties.
5. In the event a release for modified work is obtained directly from the physician, a certified letter will be sent to the injured worker along with a Return to Work Recommendations From and Light Duty Offer.
6. Monitors the entire scope of the Early Return to Work Program.

Summary

The goal of the Early Return to Work Program is to keep employees safely at work and reduce the negative impact on both the employee and the employer. *Your district name* encourages the employee to be an actual participant in his/her recovery and the return to work process. *Your district name* respects all employees and wants them to feel valued as members of the work team.

Sample

Light Duty Work Program

District Name: _____

Introduction:

The purpose of the Temporary Light Duty Work Program is to facilitate a timely and smooth transition back to regular work for employees who have experienced an on-the job illness or injury. The program is designed to be a transitional process offering temporary, light duty work assignments, as available, or to modify the work site to enhance the employee's return to their regular position.

Guidelines to be followed:

A. All light duty work is temporary in nature and is designed to facilitate a return to regular duties as soon as possible following the injury.

B. The immediate supervisor of the employee on Light Duty Status will be assigned by or his/her designee.

C. Unless specifically assigned, an employee on Light Duty Status will work a five (5) day week beginning on Monday and ending on Friday. The hours of work will be from 8:00 a.m. until 5:00 p.m., with a one (1) hour lunch period and a maximum of forty (40) hours per week.

D. While an employoee is on Light Duty Status, he/she will have no change in his/her basic pay scale, accumulation of sick leave, holidays, or seniority.

E. While an employee is on Light Duty he/she may not engage in any activities that are not specifically made an exception to his/her Light Duty Status by

F. Light Duty assignments will be typical office work which does not require physical exertion. Typical duties include: _____

_____

_____

_____

G. The District reserves the right to modify, change or discontinue the Light Duty Work Program, position, or conditions of the program at any time.

Sample

Outline for the Position of Temporary Light Duty

District Name: _____

Injured Worker Responsible to: _____

Wage: _____

Hours: _____

General Description: The purpose of this temporary light duty assignment is to facilitate an employee's transition back to his/her regular work assignment.

Your light duty assignment will be to work in the office area on a variety of light duty tasks which are within the restrictions as identified by your treating physician. If you are assigned tasks which are outside of your restrictions, as identified by your treating physician, you are to report them to a Chief Officer immediately.

Typical Duties:

- Assist with customer service
- Assist with filing
- Assist with inventory
- Assist with phones
- Assist with training
- Assist with record keeping
- Assist with cleaning
- Perform fire prevention activities
- Perform fire/EMS training activities
- Perform mapping functions
- Perform other light duty tasks as assigned by the Fire Chief or designee

Sample: Intro Letter to Doctor

Your District Letterhead

Month Day, Year

Doctor's Name
Address
City, State Zip

Subject: Employee Name: *First and Last Name*
Claim No.: Claim Number
Date of Accident: *Date of Accident*

Dear Doctor *Last Name*,

Our district has an active return to work program for employees requiring temporary restrictions to their normal job functions due to injuries on the job. The way in which we approach modified work is as follows:

1. We ask you, the treating physician, to complete a physical assessment form.
2. Upon receipt of the completed assessment form, we meet with the appropriate department head and we try to fashion a job or a variety of jobs which do not exceed the limitations you have set.
3. We then submit the job or tasks we think are appropriate to you for approval and request that you fax it back to us.
4. Upon receipt of your acceptance, we then return the employee to modified work.

This approach to modified work has given us optimal results. We hope it will not unduly inconvenience you. We have enclosed a physical assessment form for you to complete. We look forward to its timely receipt so that we can begin to work on returning *Employee Name* to employment.

We feel it is of benefit not only to the injured worker, but also to us as the employer, to return the worker to a productive capacity as soon as possible. If shorter working hours are needed or the lighter job pays the worker less, the worker receives pro-rated workers compensation benefits from our insurance carrier in addition to his wage.

Please do not hesitate to call us of you have any questions. A prompt reply will be most appreciated.

Sincerely,

Signature

cc: *Name of Your Insurance Carrier*
Enc: Return to Work Evaluation

Return form to:

RELEASE TO RETURN TO WORK

Name of worker	Claim number

Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? ☐ Yes ☐ No If yes, date: _____ (Provide closing information and complete Form 827.)

   If no, estimated medically stationary date: _____ Are there permanent restrictions? ☐ Yes ☐ No ☐ Unknown

   Next scheduled appointment date: _____

2. Worker is released to:

   ☐ full duty without limitations Date: _____ (Do not complete lines 3 through 11. Sign below.)

   ☐ modified duty from (date): _____ through (date): _____ (specify limitations below)

   ☐ modified hours specify hours: _____ from (date): _____ through (date): _____

   ☐ not released to work Est. RTW date: _____ If modified release, provide date of anticipated regular release: _____

	Hours:	**No limitations**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Other (specify)**
3. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can stand/walk a total of		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
4. At one time, worker can stand/walk		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
5. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other ____ -hour workday, worker can sit a total of		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
6. At one time, worker can sit		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	**<10**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**>100**
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:

	Right	**Left**	
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No	Dominant hand
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No	
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:

	Continuous 67-100% of the day	**Frequently 34-66% of the day**	**Occasionally 6-33% of the day**	**Intermittently 1-5% of the day**	**Not at all**
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Climb	☐	☐	☐	☐	☐
g. Balance	☐	☐	☐	☐	☐
h. Reach	☐	☐	☐	☐	☐
i. Push/pull	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of medical service provider*	Printed name	Date

440-3245 (10/05/DCBS/WCD/WEB)

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.

Sample

Employee Responsibilities While in the Temporary Light Duty Work Program

District Name: _____

The following are guidelines to follow while you are working temporary light duty:

1. You must report for work on time and follow the instructions given. Please ask questions whenever necessary. You are responsible for performing your duties in a professional manner. While on temporary light duty, you are under the same policies as all employees. Any performance issues will be addressed through the progressive disciplinary action process.
2. All work provided will be consistent with and will not exceed the physical limitations set by your physician. It is your responsibility to make sure you do not work beyond your physical limitations. If any activities produce and/or aggravate symptoms, you should report it to your supervisor immediately.
3. You will be paid your regular hourly wages while performing temporary light duty. Our Workers' Compensation insurance company will prorate your workers' compensation benefits if you are receiving less than regular wages.
4. Any absences must be reported to your supervisor.
5. Any appointments with your physician, physical therapy, etc., should be scheduled outside your work hours or at a time that is least disruptive to the workplace. You are required to provide the Supervisor with an updated Return to Work Recommendations Form following each visit.
6. Failure to report for temporary light duty work or follow your physician's recommendations can lead to loss of compensation.
7. Light duty is temporary. It is a program that Your District Name provides to assist you in returning to your regular work. No temporary light duty assignment will become permanent. The temporary light duty assignment will be evaluated at the end of thirty (30) calendar days.
8. If, due to medical complications, your physician takes you off work again, please contact your Supervisor immediately. Remember, any absences from work, due to your injury, must be authorized by your physician.
9. The Workers' Compensation Manager will monitor your physical progress and your temporary light duty assignment.

Feel free to contact your Workers' Compensation Manager with any questions or concerns.

Name of Workers' Compensation Manager: _____

Phone Number/Contact Information: _____

Sample

Return to Work
Employee Responsibilities

District Name: _____

1. When an employee has an on-the-job accident or injury, it must be reported immediately to his/her supervisor. Failure to do so could result in a claim being delayed or denied.
2. If no injury has occurred or professional medical assistance is not required, an employee must fill out and give to his/her supervisor an SDAO Incident Report by the end of the work shift.
3. If an injury does occur that results in medical treatment by a physician, an employee must fill out a SDAO Workers' Compensation 801 form within 24 hours with the employee's supervisor. If an injury requires immediate emergency medical care, the 801 form should be filled out as soon as possible following the injury.
4. An employee must inform his/her physician that there are light-duty jobs available, and provide him/her with a Return-to-Work Recommendations Form.
5. Once an employee's treating physician releases him/her to return to regular duty, the employee must notify his/her supervisor within 24 hours, and inform the supervisor of any physical restrictions or conditions. Employees can not return to work without a doctor's release. Release by the District's physician may be required.
6. If an employee is unable to report for any kind of work, the employee must call in every Monday, between the hours of 8:00 a.m. and noon (unless otherwise arranged) to his/her supervisor or other designated person to report status.
7. While an employee is off work, it is the employee's responsibility to supply their supervisor or District Administrative Office with a current telephone number (unlisted or listed) and an address where he/she can be reached.

I have read and fully understand all of the above procedures, and know my responsibilities. I understand that failure to complete my responsibilities as stated above may result in disciplinary action up to and including termination from my job and/or loss of my right to re-employment or reinstatement following injury. I have received a copy of this information.

Print Employee's Name: _____

Employee's Signature: _____ Date: _____

Sample: Offer of Light/Modified Employment for Injured Employee

(Send Regular and Certified Mail)

Job offer

Month Day, Year

Employee Name
Address
City, State Zip

RE: Injured Worker: *First and Last Name of Injured Employee*
Employer: *Name of Employer*
D/I: *Date of Injury*
Claim No: *Claim Number*

Dear *Name of Injured Employee*,

Your attending physician or authorized nurse practitioner has released you for transitional work. Your attending physician or authorized nurse practitioner reviewed and approved the enclosed transitional duty job description, the physical tasks associated with this transitional job, the location of the work offer, and has released you to the transitional job as of *Month/Day/Year*, as indicated in the enclosed work release. In that regard, your attending physician or authorized nurse practitioner has found the following job to be within your physical capabilities and the commute within your physical capacity.

Modified work is intended to be a transition from working with physical limitations due to a work injury, to ultimately performing regular job duties as physical capacities increase. Transitional work will be reassessed for appropriateness on an ongoing basis.

We ask that you report to work, as follows:

Beginning time, date and location: *Beginning time, date and location*

Report to: *First and Last Name of Supervisor*

Wage: *Wage*

Hours: *Hours of Shift (Beginning Time and Ending Time)*

Work Days: *Name the Days to be Worked*

Duration of the job: *Duration of the job*

Description of the Physical Requirements: *Description of the Physical Requirements*

IF YOU RECEIVE THIS LETTER ON OR AFTER THE DAY YOU ARE TO REPORT TO TRANSITIONAL WORK, YOU MUST CONTACT THE EMPLOYER IMMEDIATELY TO DISCUSS RETURN TO WORK AND REPORT TO WORK WITHIN 24 HOURS FROM THE DATE YOU RECEIVED THIS LETTER.

Right to Refuse Offer

Pursuant to ORS 656.268(4)(c) and OAR 436-060-0030 (5)(c)(F), a worker has the right to refuse this offer of employment without termination of temporary total disability if any of the following conditions apply:

1. The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

2. The offer is not with the employer at injury;
3. The offer is not at a work site of the employer at injury;
4. The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or
5. The offer is not consistent with an existing written shift change provision of an applicable union contract.

PURSUANT TO ORS 656.268(4)(c) and ORS 656.325(5)(a), YOUR TEMPORARY DISABILITY BENEFITS MAY CEASE IF YOU REFUSE THIS OFFER FOR REASONS OTHER THAN THOSE STATED IN THIS NOTICE.

IF YOU REFUSE THIS OFFER OF WORK FOR ANY OF THE REASONS LISTED IN THIS NOTICE, YOU SHOULD WRITE TO THE INSURER OR EMPLOYER AND TELL THEM YOUR REASON(S) FOR REFUSING THE JOB. IF THE INSURER REDUCES OR STOPS YOUR TEMPORARY TOTAL DISABILITY AND YOU DISAGREE WITH THAT ACTION, YOU HAVE THE RIGHT TO REQUEST A HEARING. TO REQUEST A HEARING YOU MUST SEND A LETTER OBJECTING TO THE INSURER'S ACTION(S) TO THE WORKERS' COMPENSATION BOARD, 2601 25th STREET SE, SUITE 150, SALEM, OREGON 97302-1282.

Sincerely,

Signature

First and Last Name
Job Title

cc: *Name of Your Insurance Carrier*

Enclosure: Copy of work release & job description

PLEASE SIGN THIS LETTER AND RETURN IT TO THE ADDRESS OR FAX NUMBER LISTED ABOVE. EACH TIME YOU RETURN TO THE DOCTOR, PLEASE BRING AN UPDATE TO YOUR EMPLOYER REGARDING YOUR RESTRICTIONS. IF YOU HAVE PROBLEMS WITH YOUR RETURN TO WORK, CONTACT YOUR SUPERVISOR IMMEDIATELY.

I UNDERSTAND THE OFFER OF LIGHT/MODIFIED EMPLOYMENT AND MY RIGHT TO REFUSE THE OFFER.

I accept this Offer: _____ **Date:** _____

I refuse this Offer: _____ **Date:** _____

Reason for refusal: _____

_____

_____

_____

I have read and understand the above information.

Employee Signature: _____ **Date:** _____

Sample: Offer of Light/Modified Employment for Injured Volunteer

(Send Regular and Certified Mail)

Volunteer Job offer

Month Day, Year

Volunteer Name
Address
City, State Zip

RE: Injured Worker: *First and Last Name of Injured Volunteer*
Employer: *Name of Employer*
D/I: *Date of Injury*
Claim No: *Claim Number*

Dear *Name of Injured Volunteer*,

Your attending physician or authorized nurse practitioner has released you for transitional work. Your attending physician or authorized nurse practitioner reviewed and approved the enclosed transitional duty job description, the physical tasks associated with this transitional job, the location of the work offer, and has released you to the transitional job as of *Month/Day/Year*, as indicated in the enclosed work release. In that regard, your attending physician or authorized nurse practitioner has found the following job to be within your physical capabilities and the commute within your physical capacity.

Modified work is intended to be a transition from working with physical limitations due to a work injury, to ultimately performing regular job duties as physical capacities increase. Transitional work will be reassessed for appropriateness on an ongoing basis.

We ask that you report to work, as follows:

Beginning time, date and location: *Beginning time, date and location*

Report to: *First and Last Name of Supervisor*

Wage: *Wage*

Hours: *Hours of Shift (Beginning Time and Ending Time)*

Work Days: *Name the Days to be Worked*

Duration of the job: *Duration of the job*

Description of the Physical Requirements: *Description of the Physical Requirements*

IF YOU RECEIVE THIS LETTER ON OR AFTER THE DAY YOU ARE TO REPORT TO TRANSITIONAL WORK, YOU MUST CONTACT THE EMPLOYER IMMEDIATELY TO DISCUSS RETURN TO WORK AND REPORT TO WORK WITHIN 24 HOURS FROM THE DATE YOU RECEIVED THIS LETTER.

Right to Refuse Offer

Pursuant to ORS 656.268(4)(c) and OAR 436-060-0030 (5)(c)(F), a worker has the right to refuse this offer of employment without termination of temporary total disability if any of the following conditions apply:

1. The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

2. The offer is not with the employer at injury;
3. The offer is not at a work site of the employer at injury;
4. The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or
5. The offer is not consistent with an existing written shift change provision of an applicable union contract.

PURSUANT TO ORS 656.268(4)(c) and ORS 656.325(5)(a), YOUR TEMPORARY DISABILITY BENEFITS MAY CEASE IF YOU REFUSE THIS OFFER FOR REASONS OTHER THAN THOSE STATED IN THIS NOTICE.

IF YOU REFUSE THIS OFFER OF WORK FOR ANY OF THE REASONS LISTED IN THIS NOTICE, YOU SHOULD WRITE TO THE INSURER OR EMPLOYER AND TELL THEM YOUR REASON(S) FOR REFUSING THE JOB. IF THE INSURER REDUCES OR STOPS YOUR TEMPORARY TOTAL DISABILITY AND YOU DISAGREE WITH THAT ACTION, YOU HAVE THE RIGHT TO REQUEST A HEARING. TO REQUEST A HEARING YOU MUST SEND A LETTER OBJECTING TO THE INSURER'S ACTION(S) TO THE WORKERS' COMPENSATION BOARD, 2601 25th STREET SE, SUITE 150, SALEM, OREGON 97302-1282.

Sincerely,

Signature

First and Last Name
Job Title

cc: *Name of Your Insurance Carrier*

Enclosure: Copy of work release & job description

PLEASE SIGN THIS LETTER AND RETURN IT TO THE ADDRESS OR FAX NUMBER LISTED ABOVE. EACH TIME YOU RETURN TO THE DOCTOR, PLEASE BRING AN UPDATE TO YOUR EMPLOYER REGARDING YOUR RESTRICTIONS. IF YOU HAVE PROBLEMS WITH YOUR RETURN TO WORK, CONTACT YOUR SUPERVISOR IMMEDIATELY.

I UNDERSTAND THE OFFER OF LIGHT/MODIFIED EMPLOYMENT AND MY RIGHT TO REFUSE THE OFFER.

I accept this Offer: _____ **Date:** _____

I refuse this Offer: _____ **Date:** _____

Reason for refusal: _____

_____

_____

_____

I have read and understand the above information.

Employee Signature: _____ **Date:** _____

The Employer-at-Injury Program
Helping employers return injured workers to work

The Employer-at-Injury Program

The Employer-at-Injury Program encourages the early return to work of injured workers. It provides incentives to employers that return their injured workers who have open claims to transitional work.

Employer use of the Employer-at-Injury Program is voluntary. The insurer responsible for the worker's claim administers the program and requests reimbursement for program costs from the Workers' Compensation Division. Reimbursed program costs don't increase employers' insurance costs.

Program reimbursements include wage subsidy, worksite modification, and certain purchases.

Wage Subsidy

Fifty percent of a worker's gross wages for a maximum of 66 work days. Reimbursement is based on the return-to-work wage.

Worksite Modification

The rental, purchase, or modification of equipment up to a maximum of $2,500 to allow the worker to perform early return-to-work job duties within the injury-related limitations.

Employer-at-Injury Program Purchases

Items a worker needs to do the job. Purchases may include:

- Tuition, books, and fees for a course of instruction to update existing skills or to meet the requirements of the job. *Maximum: $1,000*
- Tools and equipment mandatory for the job that are not already owned by the worker. *Maximum: $2,500*
- Clothing required for the job that is not normally provided by the employer and not already owned by the worker. *Maximum: $400*

Worker Eligibility

To be eligible for Employer-at-Injury Program incentives, the worker must meet the following criteria:

- Have an accepted, compensable Oregon on-the-job injury or occupational disease
- Not be released for regular work

Employer Eligibility

To be eligible for Employer-at-Injury Program incentives, the employer must meet the following criteria:

- Maintain Oregon workers' compensation insurance coverage
- Be the employer at the time of the worker's initial claim or claim reopening
- Reemploy an eligible worker in early return-to-work while the claim is open

How does an employer use the Employer-at-Injury Program?

The employer contacts the insurer responsible for the worker's claim to ask for help to meet program eligibility requirements and to obtain program assistance. Employers may use program incentives only once for each opening of the worker's claim. The insurer will help the employer:

- Identify an early return-to-work position
- Obtain a qualifying medical release for work from the worker's medical service provider
- Make necessary purchases

How reimbursement works

Within one year after a worker's participation in the Employer-at-Injury Program ends, the employer submits all insurer-required documentation to the insurer. The insurer requests reimbursement for program costs from the Workers' Compensation Division. To qualify for reimbursement, the insurer must have the following on file:

- Dated copies of the worker's work release(s)
- Documentation of the worker's early return-to-work position
- A copy of the worker's payroll records for the wage-subsidy period
- Copies of receipts for any modifications or Employer-at-Injury Program purchases
- Documentation of the worker's injury-caused obstacles to employment and how the modifications overcame these obstacles, if applicable

Rules governing EAIP

The information in this brochure summarizes the Employer-at-Injury Program. Oregon Administrative Rule 436-105 describes program requirements in further detail. To request a copy of the rules or for additional information about the Employer-at-Injury Program, employers and workers should contact their workers' compensation insurer or the Workers' Compensation Division at 800-445-3948 or 503-947-7588.

For further assistance

The Department of Consumer & Business Services has another program, the *Preferred Worker Program*, for Oregon employers and workers. The *Preferred Worker Program* encourages reemployment of qualified Oregon injured workers. Preferred Workers can offer valuable incentives to employers that hire them. For more information, call 800-445-3948.

Job Match, an online resource, helps employers and Preferred Workers find one another. The Workers' Compensation Division offers free employment-advertising space on its Website to eligible employers looking for Preferred Workers to fill job openings. The Web site is www.oregonpwp.info. Click on *Job Match* to find out more.

Employer-at-Injury Program, Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405.

If you have questions, call:

Salem		**Medford**	
Toll-free:	800.445.3948	Toll-free:	800.696.7161
Phone:	503.947.7588	Phone:	541.776.6032

Visit our Web site: www.oregonpwp.info

Preferred Worker Program

The State of Oregon Preferred Worker Program encourages the reemployment of qualified Oregon workers who have permanent disabilities from on-the-job injuries and who are not able to return to their regular employment because of those injuries. The program is funded by worker and employer contributions to the Workers' Benefit Fund. Preferred Workers can offer cost-saving options to Oregon employers who hire them.

Eligible Employers

Employers must maintain Oregon workers' compensation insurance and comply with the Oregon workers' compensation law.

Eligible Workers

Workers must have permanent disability as a result of a disabling compensable injury or disease sustained on the job in Oregon and must not be released for regular employment.

Major Program Benefits

Premium exemption: An employer does not pay workers' compensation insurance premiums or premium assessments on a Preferred Worker for three years from the date of hire.

Claim cost reimbursement: This protects the employer from the costs of a new workers' compensation claim if the Preferred Worker files during the premium exemption period.

Wage subsidy: The employer receives 50 percent wage reimbursement for the Preferred Worker for six months. Wage subsidy may be used one time each with two different employers, or twice with the same employer for two different jobs.

Employment purchases: These are items the worker is required to purchase for a job. These items must be required of all workers performing the job for which the worker is employed and must be items not normally provided by the employer:

- **Tuition, books, and fees** for instruction to update existing skills ($1,000 maximum expenditure).
- **Temporary lodging, meals, and mileage** to attend instruction when over night travel is required ($500 maximum expenditure).
- **Tools and equipment** mandatory for employment ($2,500 maximum expenditure).
- **Clothing** required for the job ($400 maximum expenditure).
- **Moving expenses** for a job in Oregon if the new worksite is more than 50 miles from the primary residence.
- **Initiation fees, or back dues and one month's current dues**, required by a labor union.
- **Occupational certification, licenses, and related testing cost** ($500 maximum expenditure).
- **Worksite creation** costs that the employer will incur in order to have a place for the Preferred Worker to perform his or her job ($5,000 maximum expenditure).
- **Miscellaneous** purchases that don't fit in any other categories but are necessary for the Preferred Worker to find, accept, or retain employment in Oregon ($2,500 maximum expenditure per claim opening).

Worksite modification: Modifications can include tools, equipment, and worksite redesign needed to overcome injury-caused limitations so the worker can do the job. They may be used once with one employer and once with a second employer or twice with the same employer if there is a job change. Modifications are limited to a maximum of $25,000 on the claim that qualified the worker for assistance.

Note: *All program benefits are subject to division review and approval.*

Find "Return to Work" and "Preferred Worker Job Match" on our Web site at http://www.oregonpwp.info.

For more information contact an SDAO Claims Examiner at 800.305.1736.

About Us

Managed Care and Occupational Injuries
Managed Care Organizations (MCOs) are utilized by workers compensation insurers and self-insured employers to provide injured workers appropriate, cost-effective medical treatment and disability management, and to ensure the claims process and medical care are moving forward. MCOs, like OHS, provide services such as:

- A network of physicians and other medical providers who understand occupational injury and illness care.
- Medical and disability management services, working with the MCO panel of physicians and other health care professionals to promote cost-effective, timely, and appropriate medical care, and to move injured workers towards the highest level of physical functioning possible as quickly as possible.
- Reducing the hassles and headaches of claims administration by providing timely and complete medical and return to work information.

MCOs do not decide whether to accept or deny workers' compensation claims, but do provide medical and disability management expertise.

What Sets Oregon Health Systems Apart from other MCOs?

- No Conflict of Interest - Oregon Health Systems is the only MCO that is not owned by a hospital or large healthcare provider. We are free to contract with providers and health care systems based on quality, service, and cost vs. alliance to one hospital or network system.
- Experienced Physician Network - Our providers are selected based on proven results and experience in the treatment of work-related injuries and illnesses.
- Proactive Approach to Medical Management - Our approach to medical management is to follow the care of the injured worker from enrollment into our system until resolution, identifying key events and communicating on a regular basis with physicians and claims adjusters, and utilizing our cadre of physician advisors and our Medical Director to work with a panel physician on difficult or complex cases.

Why use an MCO?
Use of a state-certified MCO allows the insurer to direct the care of an injured worker to a panel of providers experienced in the treatment of work-related injuries and illnesses, or to their family physician, who agrees to work with the MCO in the care of the injured worker. The MCO works with the attending physician to receive timely and appropriate care, and address return-to-work issues to move injured workers towards the highest level of physical functioning possible as quickly as possible.

Additionally, outside of a managed care contract, treatment disputes must go to the Medical Director of the Workers' Compensation Division. When an MCO contract is in place, all treatment disputes must first be handled within the MCO. We believe panel physicians participating in the review of medical disputes through OHS' Medical Review Committee sets the standard for quality medical review.

We're everywhere you need us...
First certified in limited areas in 1991, OHS now offers services to workers throughout the entire state of Oregon. We are the only MCO certified for the entire state. We also offer managed care services in Montana as Montana Health Systems, and other case management and cost containment services in several other western states.

Oregon Health Systems, Inc.

Employee Information

Your employer or Workers' Compensation insurer has contracted with Oregon Health Systems, Inc. (OHS) to provide the services of a managed care organization (MCO) to employees injured on the job.

We understand that dealing with an injury can sometimes be stressful and confusing. We therefore recommend that you become familiar with the OHS procedures *before* you may need to seek care for a work-related injury or illness.

Following are answers to some of the more commonly-asked questions concerning our managed care program. Should you have additional questions, please feel free to contact your workers' compensation insurance representative, or Oregon Health Systems directly at (503) 639-6080, or (800) 525-0394.

What is Oregon Health Systems?
OHS is a state-certified managed care organization. We contract with physicians, hospitals, and other health care providers to provide medical services to covered employees with work-related injuries or illnesses. Our providers are carefully selected and trained in the treatment of work-related conditions. OHS, and the health care providers in our network, want to make sure that timely, effective, and convenient medical services are available for our covered workers. OHS will also be working closely with your doctor and insurer to help you return to gainful employment as soon as possible after an on-the-job injury or illness.

Is OHS a Workers' Compensation insurance company?
No. OHS contracts *with* insurance companies and self-insured employers to provide managed care services to injured workers. We monitor medical care that is provided to ensure that it is appropriate and necessary, and that it meets our quality standards.

OHS does *not* make decisions on acceptance or denial of claims, payment of time loss or medical benefits, or any other workers' compensation benefits. Decisions concerning these and all other claims issues remain the responsibility of the claims examiner for the insurer or self-insured employer.

Am I required to see one of the OHS doctors if I am injured on the job and need medical care?
In most cases, yes. Once your claim is "enrolled" by your workers' compensation insurance carrier (which means you have been given written notice of your requirement to treat within the MCO) you will be required to treat with an MCO provider unless one of the circumstances explained below applies. However, if you are enrolled in the MCO prior to your claim being accepted, your workers' compensation insurance company will be required to pay for all reasonable and necessary medical services related to your claim received from an MCO member provider that are not otherwise covered by your group health insurance. This requirement applies even if your claim is denied, until you receive notice of the denial, or until three days after the denial is mailed, whichever occurs first.

The situations in which you may receive compensable care from a non-OHS provider after your claim is enrolled follow.

1. **You have a private physician or nurse practitioner who qualifies as a primary care physician or authorized nurse practitioner.**

   Your family physician or authorized nurse practitioner may qualify to treat you under the managed care arrangement, even if he or she is not on the OHS list of contracted providers.

To qualify:

- Your provider must be a medical doctor (M.D.) or osteopath (D.O.) or authorized nurse practitioner.
- Your doctor must be a family practitioner, general practitioner, internal medicine specialist or authorized nurse practitioner.
- You must have a history of being treated by that doctor or authorized nurse practitioner, or have the doctor or authorized nurse practitioner as a designated primary care provider under your group health plan.
- The doctor or authorized nurse practitioner must agree to abide by all terms and conditions of Oregon Health Systems, and must refer you to an OHS provider for any additional care you may need.

If your authorized nurse practitioner is qualified to provide your care, he or she will be allowed to authorize time loss for 60 days from the date of the first nurse practitioner visit on the initial claim and may provide medical treatment for 90 days from the date of the first nurse practitioner visit on the initial claim.

2. **There are fewer than three MCO providers available in a given category in OHS' geographical service area.**
   You may be allowed to seek treatment from a non-OHS provider if there are fewer than three OHS providers in the following categories:

   - Acupuncturist (L.A.C.)
   - Optometrist (O.D.)
   - Chiropractor (D.C.)
   - Dentist (D.M.D. or D.D.S.)
   - Naturopath (N.D.)
   - Osteopath ((D.O.)
   - Physician (M.D.)
   - Podiatrist (D.P.M.)
   - Physical therapist
   - Psychologist
   - Authorized nurse practitioner

   All out-of-panel treatment will be subject to OHS's utilization and treatment standards.

3. **You reside outside OHS' geographical service area.**
   If you reside outside OHS' geographical service area you may select a non-MCO provider if they practice closer to your residence than an MCO provider of the same category and if they agree to the terms and conditions of the MCO.

If you think you qualify for any of the above exceptions and would like consideration for out-of-panel treatment, please contact Oregon Health Systems.

Should you receive care from a provider who does not meet the above criteria for out-of-panel treatment, your Workers' Compensation insurer will not be required to pay for medical services. In addition, the provider will not be allowed to authorize your time loss from work.

A list of OHS providers in your geographical service area will be provided to you at the time you have a work-related injury or illness that is subject to the MCO agreement. You may also obtain a complete panel list for the entire state by contacting OHS.

What if I live a long distance from OHS' service area?
If you live more than one hundred miles from OHS' geographic service area, you will not be subject to the MCO arrangement.

What if I am currently receiving care from a non-MCO provider for a work-related injury or illness at the time I am enrolled into the MCO program?
You will be required to treat with an MCO provider, with the exceptions noted above. However, if you have not yet been declared medically stationary, are required to change physicians, and the MCO determines that it would be medically detrimental for you to change physicians, you would not be subject to the MCO requirements until you become medically stationary or choose to change physicians, whichever occurs first.

If you are not yet medically stationary and think that a change of physicians would be medically detrimental to you, you may request review of your situation by the MCO. To request review, please submit your request in writing to the address listed within 30 days of the date of the action. Failure to request review in writing within 30 days precludes further appeal.

What do I do if there is a medical emergency and I'm not able to see an OHS provider?
In true emergency cases, OHS, your employer and your insurer believe the first priority is to have the medical emergency taken care of and the worker removed from immediate danger. An emergency is defined as a medical condition that if treatment is not rendered immediately, creates the risk of death, serious disability or serious medical consequences.

If your claim is subject to the MCO, and you are far away from or otherwise unable to receive care from an OHS provider in an emergency, you should seek care from the nearest appropriate medical facility. After you are out of immediate danger, all follow-up care will be provided within the MCO. If emergency care is needed and an appropriate OHS facility is available, care should be sought from the OHS member facility if possible.

If you are in need of emergency care and unsure of where to go, seek medical care from the closest available medical facility. Emergency care should not be used as a substitute for routine, ongoing medical care from an attending physician.

What about medical care I might need for non-work related conditions?
OHS has no involvement with medical care that you might seek for illnesses or injuries that are not job-related. You will continue to receive group health benefits, if any, as provided by your employer. Contact your Human Resources or Employee Benefits department for information concerning these benefits.

What do I do if I am injured on the job?
Report all injuries to your designated employer representative immediately. He or she will provide you with necessary forms to complete.

Once your claim is enrolled in the MCO, if you require medical care, you may choose to see any physician on the OHS Provider list who is listed as an "Attending Physician", or an Authorized Nurse Practitioner listed under Non-Attending Physicians. Authorized Nurse Practitioners will be allowed to authorize time loss for 60 days from the date of the first nurse practitioner visit on the

initial claim and may provide medical treatment for 90 days from the date of the first nurse practitioner visit on the initial claim. Or, you may treat with a non-OHS provider as explained previously.

If you have trouble scheduling an appointment or need help in accessing care, OHS will be happy to assist you.

In addition, you should always follow all of your company's rules relating to work-related injuries including reporting requirements, modified work schedules, etc.

What can I do if I disagree with an action taken by OHS or its member physicians?
OHS wants to make sure you receive timely, effective and convenient medical services for your work-related injury. However, should a dispute arise concerning your care within the MCO, you may request review through OHS' Internal Dispute Resolution Process.

Such request must be made in writing within 30 days of the action giving rise to the dispute. You should state the specific issue for which you are requesting review, and include any information you think we should consider in our review. Address your requests to Administrator, Oregon Health Systems, P.O. Box 3810, Tualatin, OR 97062-3810. If you appeal timely, we will review the disputed decision and notify you of our decision within 60 days of your request. Thereafter, if you continue to disagree with our decision, you may appeal to the Director of the Department of Consumer and Business Services for further review.

Please note that failure to request a review in writing to Oregon Health Systems within 30 days of the action giving rise to the dispute means you lose your right of further appeal to the Director of DCBS.

For more information, contact:

Oregon Health Systems, Inc.
PO Box 3810
Tualatin OR 97062-3810
Phone 503.639.6080
Toll-free 800.525.0394
Fax 503.639.8521
Hours of Operation: 8:00 am - 5:00 pm (PST)
Email: info@ohs-inc.com
Website: www.ohs-inc.com

Payroll Reporting for Workers' Compensation
Most Frequent Discrepancies

1) Some districts do not exclude vacation hours from gross payroll as they feel it is not worth the time. However, if vacation hours are tracked separately from sick and holiday hours they can be excluded from gross payroll. For districts with smaller budgets, it is recommended that you follow this rule since any amount of savings is helpful.

2) Some districts exclude holiday and sick pay from gross payroll because they assume that if the employee is away from work there is no risk of injury. Therefore, they do not feel it is necessary to pay premiums for those hours. However, unlike the vacation exclusion which is restricted to workers' compensation programs in Oregon, both holiday and sick pay must be included.

3) Some districts have been unintentionally misusing class code 8742 (director/sales/ collector). For our districts, this code is used typically for supervisory office individuals who frequently travel. These individuals are usually involved in promoting the district through sales efforts and visits with external sources.

4) Some districts have not been excluding excess overtime from gross pay. Excluding excess overtime from gross pay means the "extra" earnings employees receive for working overtime is not reported. In other words, overtime is reported at the employee straight time wage. If your district pays time-and-a-half for overtime hours, you can exclude one-third (1/3) of overtirne pay for each employee. If your district pays double-time, you can exclude one-half (1/2) of overtime pay.

5) Some districts have not accurately tracked time which is required when individuals are split between two or more class codes. Splitting hours between class codes is acceptable if your district has "Accurate Verifiable Records" on a daily basis. This typically involves time sheets with each individual's name, duties performed, and amount of time on each duty. There are two examples verifiable time records after the next page.

Fire Districts

1) Some fire districts have been using class code 8391 (Cty Vehicle/Equipment Repair) for building maintenance and shop workers. However, these duties fall under the normal duties of firefighters and therefore must be classed in code 7704 (Firefighter) for employees and 8411(Vol. Firefighter) for volunteers.

Division of Payroll

The following is an explanation of the splitting of payroll between two or more class codes. One benefit of splitting class codes is a significant savings in premiums when **verifiable records*** are maintained.

The statute generally provides that when any employee performs duties that apply to several different class codes, you may divide that person's payroll between two or more classifications, **PROVIDED separate verifiable payroll records are adequately maintained. When verifiable payroll records are not maintained, that individual's payroll MUST be assigned to the highest rated classification for any of the duties performed**.

**Verifiable Records*

Verifiable records are daily records of the duties performed by each employee and the time allocation to each duty. **Estimates or estimated percentages** of time spent in the different duties are not acceptable as verifiable records.

Records should include:

1) A specific description of the employee's performed duties separated by classification code.
2) Hourly records by classification for each individual on a daily basis, including total hours worked.
3) Conversion of hours to payroll dollars.
4) Summary of dollars and hours during each payroll period.

On the following page are two examples of a verifiable records that meets the above requirements.

Sample 1: Verifiable Record

Employee Name: John Q. Sample Hourly Rate: $9.00

Date	Job Description	Code 8810	Code 7153J	Code 7423
04/01/2008	Computer Entry, Payroll	4		
	Repaired Railroad Ties		3	
	Refueled Aircraft			1
04/02/2008	Financial Statements	3		
	Aircraft Control			3
	Railroad Fills		2	
	Total Hours	7	5	4
	Total Dollars	$63.00	$45.00	$36.00

Employee Signature: _____

Sample 2: Verifiable Record

Employee Name: John Q. Sample Hourly Rate: $9.00

Date	Job Description	Class Code	Hours
04/01/2008	Computer Entry, Payroll	8810	4
	Repaired Railroad Ties	7153J	3
	Refueled Aircraft	7423	1
04/02/2008	Financial Statements	8810	3
	Aircraft Control	7423	3
	Railroad Fills	7153J	2

Total Hours	16	
8810	7	$63.00
7423	4	$36.00
7153	5	$45.00
Total Dollars		$144.00

Employee Signature _____

Gross Payroll Defined

In accordance with ORS 656-005 (22), OAR 436-85 and rules established by the National Council on Compensation Insurance (NCCI), gross wages subject to premium assessment are to be calculated and reported based on the following guidelines:

Inclusions

- Base pay for all time worked
- Commissions
- Holiday pay
- Sick pay
- Assumed wages (Volunteers and unpaid Board Members)
- Bonus pay anticipated under the contract of employment
- Employee contributions to 401K or Cafeteria plans
- Corporate Officer wages for all covered officers, subject to Oregon minimum ($300/week) & maximum ($2,700/week)
- Employer paid wage while on Jury Duty
- Payroll amounts contributed by employees under Public Employees' Retirement System (PERS)

Exclusions

- Vacation pay
- Dismissal or severance pay
- Discretionary bonuses, or bonuses to reward workers for safe working practices
- Tips and gratuities
- Excess overtime pay - that portion of the overtime rate which is in excess of the straight time rate (i.e., if the straight time rate is $10/hr and the O.T. rate is $15/hr: exclude the extra $5/hr.
- Payroll amounts picked up by the employers under Public Employees' Retirement System (PERS)
- Payroll for qualifying Preferred workers in accordance with OAR 436-110-200 and 436-110-400.

Volunteer Coverage

Oregon Law dictates the procedures and documentation that is required for municipal volunteer workers' compensation coverage. To comply with the law, if a district elects to cover volunteers they must have a volunteer resolution adopted by the board, report an assumed wage for any volunteer classification(s), and submit a roster of volunteers to SDAO.

Resolution

Attached is a sample resolution for your board to modify and adopt if your district elects to provide volunteer workers' compensation coverage through SDAO. Your district only needs to adopt a volunteer resolution once unless changes are made to the categories of volunteers (i.e. Board of Directors, Public Safety Volunteers, or Other Volunteers) your district elects to cover.

Election of Volunteers

If your district elects to cover volunteers you must report an assumed wage for the NCCI Classification Code followed by a "V" on the *Board and Volunteer Election Form*. For example, if you elect to cover clerical volunteers you must report an assumed wage for Classification Code 8810V on the form.

Payroll for Classification Code 8411 (Municipal Volunteers - Firefighters) is reported using an assumed monthly wage of not less than $800 per month. The assumed monthly wage may be increased at the district's discretion in increments of $100.

Payroll for all other volunteer classifications should be calculated using an assumed wage equal to at least Oregon minimum wage ($7.95 per hour) multiplied times actual hours volunteered.

Election of Volunteer Board Members

Indicate on the *Board and Volunteer Election Form* if you elect to cover your district's volunteer Board of Directors under NCCI Classification Code 8742B. The minimum assumed payroll for 8742B is $2,400 per year.

If your Board of Directors are paid, report their payroll on the *Renewal Update Form* under NCCI Classification Code 8742.

Volunteer Roster

By Oregon law your district must keep a roster of volunteers who are covered under your workers' compensation policy. Attached is a *Volunteer Roster* you may use, or you can create your own form. The roster should be completed and returned with your district's *Board and Volunteer Election Form* at renewal. Your online volunteer roster, available at www.sdao.com, needs to be updated quarterly.

Contact SDAO's Underwriting Department at 800.285.5461 if you have any questions.

656.03 1 Coverage for Municipal Volunteer Personnel

(1) All municipal personnel, other than those employed full time, part time, or substitutes therefore, shall, for the purpose of this chapter, be known as volunteer personnel and shall not be considered as workers unless the municipality has filed the election provided by this section.

(2) The county, city or other municipality utilizing volunteer personnel as specified in subsection (1) of this section may elect to have such personnel considered as subject workers for purposes of this chapter. Such election shall be made by filing a written application to the insurer, or in the case of a self-insured employer, the Director of the Department of Consumer and Business Services, that includes a resolution of the governing body declaring its intent to cover volunteer personnel as provided in subsection (1) of this section and a description of the work to be performed by such personnel. The application shall also state the estimated total number of volunteer personnel on a roster for each separate category for which coverage is elected. The county, city or other municipality shall notify the insurer, or in the case of self-insurers, the director, of changes in the estimated total number of volunteers.

(3) Upon receiving the written application the insurer or self-insured employer may fix assumed wage rates for the volunteer personnel, which may be used only for purposes of computations under this chapter, and shall require the regular payment of premiums or assessments based upon the estimated total numbers of such volunteers carried on the roster for each category being covered. The self-insured employer shall submit such assumed wage rates to the director. If the director finds that the rates are unreasonable, the director may fix appropriate rates to be used for purposes of this section.

(4) The county, city or municipality shall maintain separate official membership rosters for each category of volunteers. A certified copy of the official membership roster shall be furnished to the insurer or director upon request. Persons covered under this section are entitled to the benefits of this chapter and they are entitled to such benefits if injured as provided in ORS 656.202 while performing any duties arising out of and in the course of their employment as volunteer personnel, if the duties being performed are among those:

(a) described on the application of the county, city or municipality; and
(b) required of similar full-time paid employees.

(5) The filing of claims for benefits under this section is the exclusive remedy of a volunteer or a beneficiary of the volunteer for injuries compensable under this chapter against the state, its political subdivisions, their officers, employees, or any employer, regardless of negligence. [Formerly 656.088; amended by 1969 c.527s.1; 1979 c.815s.2; 1981c.854s.5; 1981c.874s.1]

Sample: Volunteer Agreement with Workers' Compensation Coverage

Volunteer Agreement

A. In consideration for being permitted to perform the below-described activity(ies), the undersigned volunteer agrees to indemnify and hold harmless _____, its officers, agents, and employees from and against all liability, claims, and demands, on account of injury, loss, or damage to volunteer, including without limitation, claims arising from bodily injury, personal injury, sickness, disease, death, property loss or damage, employment claims, or any other loss of any kind whatsoever, which the volunteer may personally sustain during the course of performing his/her activities with the district.

B. Volunteer acknowledges that they are not a district employee and have no employment rights. Their acceptance and activities as a volunteer shall be at the discretion of the District, and such services may be discontinued at any time without cause.

C. Description of activity(ies) to be performed:

_____

_____

D. Period during which activity(ies) are to be performed: _____.

Executed on this _____ day of _____, 2009 by _____ and the person whose name and signature appear below:

Agreed to by: _____ Agreed to by: _____

Volunteer signature

_____ Date: _____

Printed name of signer

Parental/legal guardian signatures: (Each parent/legal guardian must complete the following if the volunteer is under 18 years of age.)

I am/we are the parent(s)/legal guardian(s) of the volunteer and by my/our signature, agree to be bound by and responsible for all of the provisions of this Release and Indemnification Agreement, on behalf of ourselves, the volunteer, and the successors, Representatives, heirs, executors, assigns, and transferees of ourselves and the volunteer. I/we consent to the execution of this Release and Indemnification Agreement and Participation in the above-described activity(ies).

By: _____ Date: _____

By: _____ Date: _____

Printed names of parent(s)/legal guardian(s)

_____ _____

Volunteer Agreement

A. In consideration for being permitted to perform the below-described activity(ies), the undersigned volunteer agrees to hold harmless _____, its officers, agents, and employees from and against all liability, claims, and demands, on account of injury, loss, or damage to volunteer, including without limitation, claims arising from bodily injury, personal injury, sickness, disease, death, property loss or damage, employment claims, workers' compensation claims, or any other loss of any kind whatsoever, which the volunteer may personally sustain during the course of performing his/her activities with the district.

B. Volunteer acknowledges that there is **no workers' compensation** coverage available to the volunteer for activities performed within this agreement.

C. Volunteer acknowledges that they are not a district employee and have no employment rights. Their acceptance and activities as a volunteer shall be at the discretion of the District, and such services may be discontinued at any time without cause.

D. Description of activity(ies) to be performed:

_____

_____

E. Period during which activity(ies) are to be performed: _____.

Executed on this ____ day of _____, 2009 by _____ and the person whose name and signature appear below:

Agreed to by: _____ Agreed to by: _____

Volunteer signature

_____ Date: _____

Printed name of signer

Parental/legal guardian signatures: (Each parent/legal guardian must complete the following if the volunteer is under 18 years of age.)

I am/we are the parent(s)/legal guardian(s) of the volunteer and by my/our signature, agree to be bound by and responsible for all of the provisions of this Release and Indemnification Agreement, on behalf of ourselves, the volunteer, and the successors, Representatives, heirs, executors, assigns, and transferees of ourselves and the volunteer. I/we consent to the execution of this Release and Indemnification Agreement and Participation in the above-described activity(ies).

By: _____ Date: _____

By: _____ Date: _____

Printed names of parent(s)/legal guardian(s)

_____ _____

Sample

Volunteer Resolution

Resolution No._____

A RESOLUTION EXTENDING WORKERS' COMPENSATION COVERAGE TO VOLUNTEERS OF *ENTER COMPLETE LEGAL NAME OF DISTRICT HERE*.

WHEREAS, *ENTER COMPLETE LEGAL NAME OF DISTRICT HERE* elects the following:

Pursuant to ORS 656.031. workers' compensation coverage will be provided to the classes of volunteer workers as indicated below (checked "Applicable") and listed on the attached Volunteer Election Form(s).

Board Members Applicable ❑ Not Applicable ❑
Public Officials on unpaid boards will be covered only for administrative and clerical functions while performing their authorized duties as elected officials.

Public Safety Volunteers Applicable ❑ Not Applicable ❑
Public Safety Volunteers are covered at the assumed monthly wage indicated on the attached Volunteer Election Form(s).

Other Volunteers Applicable ❑ Not Applicable ❑
Non-public safety volunteers and board members volunteering for duties other than administration and clerical functions will use the attached Volunteer Election Form(s) to keep track of their hours and have their assumed payroll reported in the correct Class Code for all their types of work using Oregon minimum wage.

A roster of active board members and volunteers will be kept monthly for reporting purposes and submitted to SDAO quarterly or more frequently upon request.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of *ENTER COMPLETE LEGAL NAME OF DISTRICT HERE* to provide workers' compensation coverage as indicated above.

ADOPTED by the Board of Directors of *ENTER COMPLETE LEGAL NAME OF DISTRICT HERE* this _____ day of _____, 2009.

_____
Name and Title of Authorized Representative

ATTESTED BY *NAME/TITLE* this _____ day of _____ , 2009.

_____
Name and Title

Board and Volunteer Election Form

Special Districts Association of Oregon

Policy Year: _____

District Name: _____

Board Members listed for Class Code 8742B will be covered only for administrative and clerical functions at board/committee meetings. If board members are performing functions other than administrative or clerical duties they must also be listed on the Volunteer Roster and payroll must be reported in the Other Volunteers section to be eligible for coverage.

Unpaid Board of Directors Column (1) x Column (2) x Column (3) = Column (4)					
Class Code	**Job Duty**	**(1)** **No. of Board Members**	**(2)** **No. of Meetings Annually**	**(3)** **Reimbursement per Meeting ($50 minimum)**	**(4)** **Total Estimated Assumed Payroll ($2,400 minimum)**
8742B	Board of Directors				

Public Safety Volunteers listed for Class Code 8411 use an assumed monthly wage of no less than $800 per volunteer per month (regardless if one day or 31 days are volunteered) for contribution payment and calculation of benefits. This assumed monthly wage may be increased at the district's discretion in increments of $100, up to a maximum of $2,400.

Public Safety Volunteers Column (1) x Column (2) = Column (3)				
Class Code	**Job Duty**	**(1)** **Est. # of Volunteer Months***	**(2)** **Assumed Monthly Wage ($800 min.)**	**(3)** **Total Estimated Assumed Payroll**
8411	Ambulance Driver			
8411	Ambulance Technician			
8411	Crime Prevention Unit			
8411	Sheriff			
8411	Emergency Medical Technician			
8411	Explorer Scout			
8411	Fire Chief/Asst. Fire Chief			
8411	Firefighter			
8411	Police Officer			
8411	Police Reserve			
8411	Probation Officer			
8411	Search and Rescue			
8411	Sheriff's Posse			
8411	Quick Response			
8411	Other (please specify):			
8411A	Support, Non-Firefighting: # Vol _____ x # Hrs _____ x # Months _____ x Hourly Wage _____ =			

*Estimate the number of volunteer months for each position and enter the total on the appropriate line in Column (1). Some volunteers are not active every month, i.e., one volunteer firefighter may be active five months out of the year, two volunteer firefighters may be active 12 months out of the year, and five volunteer firefighters may be active only one month out of the year. Thus, the number of volunteer firefighter months would be 34.

Board and Volunteer Election Form

District Name: _____

Other Volunteers listed for all Class Codes other than Board Member (8742B) and Public Safety Volunteers (8411) use an assumed payroll computed at Oregon minimum wage using actual hours worked and reported in the appropriate Class Code with a "V" added to the end.

SDAO's ability to provide workers' compensation coverage for volunteers is directly related to each entity's ability to keep verifiable records of the names and hours worked by participants. Claims adjusters will verify coverage at the time a claim is filed.

Other Volunteers Column (1) x Column (2) x Column (3) x Column (4) = Column (5)						
Class Code	**Job Duty**	**(1) Est. # of Vol. per month**	**(2) No. of Hours per month**	**(3) No. Of Months per year**	**(4) ≥ Oregon Minimum Wage**	**(5) Total Estimated Assumed Payroll**
0042V	Landscaping - V					
0050V	Grove Caretaking Operations - V					
0106V	Tree Pruning, Spraying - V					
0113V	Fish Hatchery and Drivers - V					
0124V	Tree Planting - V					
0251V	Irrigation Works - V					
2702V	Forest Fire Fighting Special Employee - Doctor - V					
4361V	Photography - V					
4511V	Analytical Chemist - V					
5183V	Plumbing - V					
5403V	Carpentry NOC - V					
5445V	Wallboard Install w/in Bldg - V					
5474V	Painting - V					
5479V	Insulation Work NOC & Drivers - V					
5506V	Street and Road Construction – Paving/Repaving/Drivers- V					
5507V	Street and Road Construction- Subsurface Work- V					
5606V	Contractor/Executive Supervisor - V					
5645V	Window/Door Installer - V					
6217V	Excavation NOC - V					
6229V	Irrigation Systems Construction - V					
6306V	Sewer Construction - V					
6319V	Gas & Water Main Construction - V					
6400V	Metal Fence Erection - V					
6834V	Boat Building and Repair - V					
6836V	Marina - V					

Board and Volunteer Election Form

District Name: _____

Other Volunteers Column (1) x Column (2) x Column (3) x Column (4) = Column (5)						
Class Code	**Job Duty**	**(1) Est. # of Vol. per month**	**(2) No. of Hours per month**	**(3) No. Of Months per year**	**(4) ≥ Oregon Minimum Wage**	**(5) Total Estimated Assumed Payroll**
6876V	Divers – V					
7024V	Vessels NOC (If Any) - V					
7090V	Boat Livery/Boats Under 15 Tons - V					
7153JV	Railroad Operations (If Any) – V					
7335JV	Dredging (If Any) – V					
7360V	Freighthandler NOC – V					
7370V	Drivers/Attendants - V					
7380V	Chauffeurs and Helpers NOC - V					
7382V	Bus Company and Drivers - V					
7403V	Aircraft Operation - V					
7520V	Waterworks Operations - V					
7539V	Electric Power - V					
7580V	Sewage Plant Operations - V					
7610V	Radio or TV Broadcasting - V					
7720V	Police Officers- V					
8006V	Store - Dry Goods - V					
8010V	Wholesale and Retail Stores - V					
8017V	Store - Retail - V					
8018V	Wholesale NOC - V					
8227V	Municipal Maintenance Yard - V					
8232V	Lumber Yard - V					
8385V	Bus Company - Garage - V					
8601V	Engineer or Architect - V					
8720V	Insurance Inspection & Valuation - V					
8742V	Director/Sales/Collectors - V					
8810V	Clerical Office Employee - V					
8820V	Attorney - V					
8824V	Nursing Home Health Care - V					
8825V	Nursing Home Food Service - V					
8826V	Nursing Home Other Services - V					
8832V	Clinic - V					
8833V	Hospital - Professional EE's - V					

Board and Volunteer Election Form

District Name: _____

Other Volunteers Column (1) x Column (2) x Column (3) x Column (4) = Column (5)						
Class Code	**Job Duty**	**(1) Est. # of Vol. per month**	**(2) No. of Hours per month**	**(3) No. Of Months per year**	**(4) ≥ Oregon Minimum Wage**	**(5) Total Estimated Assumed Payroll**
8835V	Nursing – V					
8868V	School Professional Employee - V					
9014V	Buildings Operation by Contractor- V					
9015V	Buildings Operation by Owner- V					
9016V	Kiddie Ride Operators - V					
9040V	Hospital - All Others - V					
9052V	Rooming House/Boarding House - V					
9061V	Club NOC- V					
9063V	YMCA/YWCA - All Employees - V					
9064V	Child Day Camp - V					
9079V	Restaurant NOC - V					
9101V	School -All Other Employees - V					
9102V	Park NOC – All Employees – V					
9154V	Theatre Employees NOC - V					
9182V	Athletic Team - Operation - V					
9220V	Cemetery Operations - V					
9349V	School Cafeteria/Kitchen EE's - V					
9366V	Hospital - Cafeteria - V					
9402V	Street and Sewer Cleaning - V					
9410V	Municipal County Employee NOC - V					
9516V	Radio, TV, Video & Audio Equip. - V					
9519V	TV/Radio Install and Repair - V					

Board and Volunteer Roster

Special Districts Association of Oregon

Policy Year: _____

District Name: _____

Board Member Roster

Class Code	Name of Board Member	Job Duty
8742B		Board Member
8742B		Board Member
8742B		Board Member
8742B		Board Member
8742B		Board Member

If Board Members are to be covered for activities other than administrative of clerical functions at board/committee meetings, they must also be included on the Volunteer Roster (below) with the appropriate Class Code.

Volunteer Roster

Class Code	Name of Volunteer	Job Duty

What's inside ...

In this packet, you'll find everything you need to complete OSHA's *Log* and the *Summary of Work-Related Injuries and Illnesses* for the next several years. On the following pages, you'll find:

- ***Overview: recording work-related injuries and illnesses*** — General instructions for filling out the forms in this packet and definitions of terms you should use when you classify your cases as injuries or illnesses.
- ***How to fill out the Log*** — An example to guide you in filling out the *Log* properly.
- ***Log of Work-Related Injuries and Illnesses*** — Several pages of the *Log*; make copies of the *Log* if you need more. Notice that the *Log* is separate from the *Summary*.
- ***Summary of Work-Related Injuries and Illnesses*** — Removable *Summary* pages for easy posting at the end of the year. Note that you post the *Summary* only, not the *Log*.
- ***Worksheet to help you fill out the Summary*** — A worksheet for figuring the average number of employees who worked for your establishment and the total number of hours worked.

Take a few minutes to review this packet. If you have any questions, visit us online at www.orosha.org or call your local OR-OSHA office. We'll be happy to help you.

OSHA
Forms for Recording Work-Related Injuries and Illnesses

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Oregon Occupational Safety & Health Division (OR-OSHA)

In compliance with the Americans With Disabilities Act (ADA), this publication is available in alternative formats. Call the OR-OSHA public relations manager, (503) 378-3272 (V/TTY).

Overview: *recording work-related injuries and illnesses*

The *Log of Work-Related Injuries and Illnesses* (OSHA Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened. The *Summary* — a separate form (OSHA Form 300A) — shows the totals for the year in each category. At the end of the year, post the *Summary* or an equivalent form in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace. *(Posting required from Feb. 1 to April 30.)*

Employers must keep a *Log* for each establishment or site. If you have more than one establishment, you must keep a separate *Log* and *Summary* for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury-and-illness records. For more information, see OAR 437-001-0700(20), *Employee Involvement*.

Cases listed on the *Log of Work-Related Injuries and Illnesses* are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case on the *Log* does not mean that the employer or worker was at fault or that an OSHA standard was violated.

When is an injury or illness work-related?

An injury or illness is work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. See OAR 437-001-0700(6) for the exceptions. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment.

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in the following:

- death
- loss of consciousness
- days away from work
- restricted work activity or job transfer
- medical treatment beyond first aid

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed health-care professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum. See OAR 437-001-0700(8).

You must also record the following conditions when they are worked-related:

- any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material
- any case requiring an employee to be medically removed under the requirements of an OSHA health standard
- any standard threshold shift (STS) in hearing (i.e., cases involving an average hearing loss of 10 dB or more in either ear, and hearing is 25 dB above and audiometric zero in the same ear.)
- tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health-care professional after exposure to a known case of active tuberculosis

What is "medical treatment"?

Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are **not recordable**:

- visits to a doctor or health-care professional solely for observation or counseling
- diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes
- any procedure that can be labeled first aid

(See next page for more information about first aid, also see Table 6, OAR 437-001-0700(8))

What do you need to do?

1. Within seven calendar days after you receive information about a case, decide if the case is recordable under the OSHA recordkeeping requirements.
2. Determine whether the incident is a new case or a recurrence of an existing one.
3. Establish whether the case was work-related.
4. If the case is recordable, fill out the injury and illness incident report, (DCBS 801).

How do you use the *Log*?

1. Record the employee involved unless it is a privacy-concern case as described on the next page.
2. Record when and where the case occurred.
3. Describe the case as specifically as you can.
4. Classify the seriousness of the case by recording the **most serious outcome** associated with the case. Column J, other recordable cases, is the least serious and column G, death, is the most serious. (*Mark only one column.*)
5. Identify whether the case is an injury or illness. If the case is an injury, check the injury category. If the case is an illness, check the appropriate illness category.

What is first aid?

If the incident required only the following types of treatment, consider it first aid.
Do not record the following:

- using non-prescription medications at non-prescription strength
- administering tetanus immunizations
- cleaning, flushing, or soaking wounds on the skin surface
- using wound coverings, such as bandages, adhesive strips, gauze pads, butterfly bandages, etc.
- using hot or cold therapy
- using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
- using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards)
- drilling a fingernail or toenail to relieve pressure or draining fluids from blisters
- using eye patches
- using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye
- using irrigation, tweezers, cotton swabs, or other simple means to remove splinters or foreign material from areas other than the eye
- using finger guards
- using massages
- drinking fluids to relieve heat stress

How do you decide if the case involved restricted work?

Restricted work activity occurs when, as the result of a work-related injury or illness, an employer or health-care professional keeps, or recommends keeping, employees from doing the routine functions of their jobs or from working the full workday that they would have been scheduled to work before the injury or illness occurred.

How do you count the number of days of restricted work activity or the number of days away from work?

Count the number of calendar days the employee was on restricted work activity or was away from work as a result of the recordable injury or illness. Do not count the day on which the injury or illness occurred in this number.

Begin counting days from the day after the incident occurs. If a single injury or illness involved days away from work *and* days of restricted work activity, enter the total number of days for each. You may stop counting days of restricted work activity or days away from work once the total of either or their combination reaches 180 days.

Under what circumstances should you *not* enter the employee's name on the *OSHA Form 300*?

You must consider the following types of injuries or illnesses to be privacy cases, *not* to be entered on the *OSHA Form 300 Log*:

- an injury or illness to an intimate body part or to the reproductive system
- an injury or illness resulting from a sexual assault
- a mental illness
- a case of HIV infection, hepatitis, or tuberculosis
- a needlestick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material (See OAR-437-001-0700(9).)
- other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log. Musculoskeletal disorders (MSDs) are not considered privacy cases

Enter "privacy case" in the space normally used for the employee's name. You must keep a separate, confidential list of the case numbers and employee names for the establishment's privacy cases so that you can update the cases and provide information to the government if asked to do so.

If you have a reasonable basis to believe that information describing the privacy-concern case may be personally identifiable even though the employee's name has been omitted, you may use discretion in describing the injury or illness on both the *OSHA 300* and the *DCBS 801 supplemental form*. You must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but you do not need to include details of an intimate or private nature.

What if the outcome changes after you record the case?

If the outcome or extent of the injury or illness changes after you have recorded the case, simply draw a line through the original entry or, if you wish, delete or use correction fluid over the original entry. Then write the new entry where it belongs. Remember, you need to record the most serious outcome for each case.

Classifying injuries

An injury is any wound or damage to the body resulting from an event in the work environment.

Examples: Cut; puncture; laceration; abrasion; fracture; bruise; contusion; chipped tooth; amputation; insect bite; electrocution; or a thermal, chemical, electrical, or radiation burn. Sprain and strain injuries to muscles, joints, and connective tissues are classified as injuries when they result from a slip, trip, fall, or other similar accidents.

Classifying illnesses

Skin diseases or disorders

Skin diseases or disorders are illnesses involving the worker's skin that are caused by work exposure to chemicals, plants, or other substances.

Examples: Contact dermatitis, eczema, or rash caused by primary irritants, and sensitizers or poisonous plants; oil acne; friction blisters, chrome ulcers, inflammation of the skin.

Respiratory conditions

Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dust, gasses, vapors, or fumes at work.

Examples: Silicosis; asbestosis; pneumonitis; pharyngitis; rhinitus; acute congestion; farmer's lung; beryllium disease; tuberculosis; occupational asthma; reactive airways dysfunction syndrome (RADS); chronic obstructive pulmonary disease (COPD); hypersensitivity pneumonitis; toxic inhalation injury, such as metal fume fever; chronic obstructive bronchitis; and other pneumoconioses.

Poisoning

Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues or bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body.

Examples: Poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzene, benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays, such as parathion or lead arsenate; poisoning by other chemicals, such as formaldehyde.

Hearing loss

Noise-induced hearing loss is defined for recordkeeping purposes as a change in hearing threshold relative to the baseline audiogram of an average of 10 decibels or more in either ear at 2,000, 3,000, and 4,000 hertz, and the employee's total hearing level is 25 decibels or more above audiometric zero (also averaged at 2,000, 3,000, and 4,000 hertz) in the same ear.

All other illnesses

All other occupational illnesses.

Examples: Heatstroke, sunstroke, heat exhaustion, heat stress, and other effects of environmental heat; freezing, frostbite, and other effects of exposure to low temperatures; decompression sickness; effects of ionizing radiation (isotopes, X-rays, radium); effects of nonionizing radiation (welding flash, ultra-violet rays, lasers); anthrax; blood-borne pathogenic diseases such as AIDS, HIV, hepatitis B or hepatitis C; brucellosis; malignant or benign tumors; histoplasmosis; coccidioidomycosis; musculoskeletal disorders (MSDs); noise-induced hearing loss.

When must you post the *Summary*?

You must post the *Summary* only — not the *Log* — by February 1 of the year following the year covered by the form and keep it posted until April 30 of that year.

How long must you keep the *Log* and *Summary* on file?

You must keep the *Log* and *Summary* for five years following the year to which they pertain.

Do you have to send these forms to OR-OSHA at the end of the year?

No. You do not have to submit the completed forms unless specifically asked to do so.

How can we help you?

If you have a question about how to fill out the *Log*:

- Visit us on line at orosha.org
- call OR-OSHA
  (800) 922-2689 or
  (503) 378-3272

en Español: (800) 843-8086

Optional: *calculating injury and illness incidence rates*

What is an incidence rate?

An incidence rate is the number of recordable injuries and illnesses occurring among a given number of full-time workers (usually 100 full-time workers) over a given period of time (usually one year). To evaluate your firm's injury-and-illness experience over time or to compare your firm's experience with that of your industry as a whole, you need to compute your incidence rate. Incidence rates can help you identify problems in your workplace or progress made toward preventing work-related injuries and illnesses. This is also the information used by OR-OSHA to calculate potential penalty reductions.

How do I calculate an incidence rate?

You can quickly and easily compute an occupational-injury-and-illness incidence rate for all recordable cases or for cases that involved days away from work and days of restricted work. Follow instructions in paragraph (a) below for the total recordable cases, follow those in paragraph (b) for cases that involved days away from work and days of restricted work, and follow instructions in paragraph (c) for both rates.

(a) To find out the total number of recordable injuries and illnesses that occurred during the year — count the number of line entries on your *OSHA Form 300* or refer to the *OSHA Form 300A* and sum the entries for columns (G), (H), (I), and (J).

(b) to find out the number of injuries and illnesses that involved days away from work and days of restricted work (DART)— count the number of line entries on your *OSHA Form 300* that received a check mark in columns (H) and (I), or refer to the entry in columns (H) and (I) on the *OSHA Form 300A*.

(c) The number of hours all employees actually worked during the year — refer to *OSHA Form 300A* and optional worksheet to calculate this number.

You can compute the incidence rate for all recordable cases of injuries and illnesses using the following formula:

Total number of injuries and illnesses ÷ number of hours worked by all employees x *200,000 hours = total recordable case rate.*

(The 200,000 figure in the formula represents the number of hours 100 employees working 40 hours per week, 50 weeks per year would work and provides the standard base for calculating incidence rates.)

You can compute the incidence rate for recordable cases involving days away from work, days of restricted work activity, or job transfer using the following formula:

(Number of entries in column H + number of entries in column I) ÷ number of hours worked by all employees x *200,000 hours = (DART) incidence rate.*

You can use the same formula to calculate incidence rates for other variables such as cases involving restricted work activity (column (I) on *OSHA Form 300A*), cases involving skin disorders (column (M-2) on OSHA Form 300A), etc. Just substitute the appropriate total for these cases, from *OSHA Form 300A*, into the formula in place of the total number of injuries and illnesses.

What can I compare my incidence rate to?

The Bureau of Labor Statistics (BLS) conducts a survey of occupational injuries and illnesses each year and publishes incidence-rate data by various classifications (e.g., by industry, by employer size, etc.). You can get the data at www.bls.gov or by calling a BLS regional office, or by visiting www.cbs.state.or.us/imd to look at OSHA reports.

Worksheet

Total number of recordable injuries and illnesses in your establishment

÷

Hours worked by all your employees

X 200,000 **=**

Total recordable cases incidence rate

Total number of recordable injuries and illnesses with days away from work and restricted work

÷

Hours worked by all your employees

X 200,000 **=**

Cases involving days away from work and restricted work incidence rate

How to fill out the Log

How to fill out the *Log*

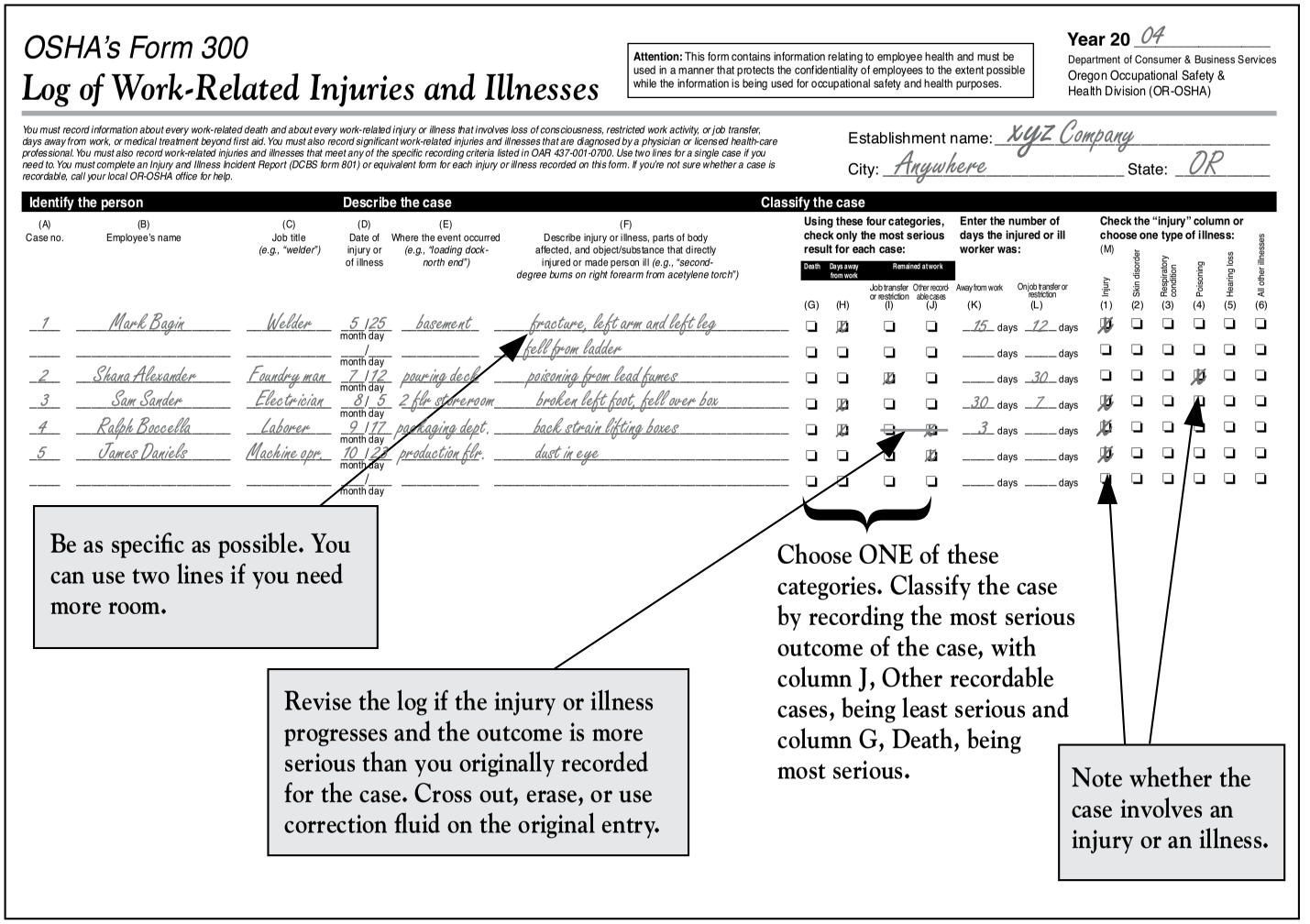
The *Log of Work Related Injuries and Illnesses* is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the log to record details about what happened and how it happened.

If your company has more than one establishment or site, you must keep separate records for each physical location that is expected to remain in operation for one year or longer.

We have given you several copies of the *Log* in this packet. If you need more than we provided, you may make photocopies.

The *Summary* — a separate form— shows the work-related injury and illness totals for the year in each category. At the end of the year, total each column and transfer the totals from the *Log* to the *Summary*. Complete the establishment information then post the *Summary* in a visible location so that your employees are aware of injuries and illnesses occurring in their workplace.

You don't post the* Log. *You post only the* Summary *at the end of the year.



OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 04

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity, or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health-care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in OAR 437-001-0700. Use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (DCBS form 801) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OR-OSHA office for help.

Establishment name: xyz Company

City: Anywhere State: OR

Identify the person			Describe the case			Classify the case															
(A) Case no.	(B) Employee's name	(C) Job title (e.g., "welder")	(D) Date of injury or of illness	(E) Where the event occurred (e.g., "loading dock-north end")	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., "second-degree burns on right forearm from acetylene torch")	Using these four categories, check only the most serious result for each case: Death (G)	Days away from work (H)	Remained at work: Job transfer or restriction (I)	Remained at work: Other recordable cases (J)	Enter the number of days the injured or ill worker was: Away from work (K)	On job transfer or restriction (L)	Check the "injury" column or choose one type of illness: (M) Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
1	Mark Bagin	Welder	5 / 25 month day	basement	fracture, left arm and left leg	☐	☒	☐	☐	15 days	12 days	☒	☐	☐	☐	☐	☐
			/ month day		fell from ladder	☐	☐	☐	☐	days	days	☐	☐	☐	☐	☐	☐
2	Shana Alexander	Foundry man	7 / 12 month day	pouring deck	poisoning from lead fumes	☐	☐	☒	☐	days	30 days	☐	☐	☐	☒	☐	☐
3	Sam Sander	Electrician	8 / 5 month day	2 flr storeroom	broken left foot, fell over box	☐	☒	☐	☐	30 days	7 days	☒	☐	☐	☐	☐	☐
4	Ralph Boccella	Laborer	9 / 17 month day	packaging dept.	back strain lifting boxes	☐	☒	☐	☒	3 days	days	☒	☐	☐	☐	☐	☐
5	James Daniels	Machine opr.	10 / 23 month day	production flr.	dust in eye	☐	☐	☐	☒	days	days	☒	☐	☐	☐	☐	☐
			/ month day			☐	☐	☐	☐	days	days	☐	☐	☐	☐	☐	☐

Be as specific as possible. You can use two lines if you need more room.

Revise the log if the injury or illness progresses and the outcome is more serious than you originally recorded for the case. Cross out, erase, or use correction fluid on the original entry.

Choose ONE of these categories. Classify the case by recording the most serious outcome of the case, with column J, Other recordable cases, being least serious and column G, Death, being most serious.

Note whether the case involves an injury or an illness.

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 ________

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity, or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health-care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in OAR 437-001-0700. Use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (DCBS form 801) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OR-OSHA office for help.

Establishment name: ____________________

City: ____________________ State: ________

Identify the person			Describe the case			Classify the case											
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., "welder"*)	(D) Date of injury or of illness	(E) Where the event occurred (*e.g., "loading dock-north end"*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., "second-degree burns on right forearm from acetylene torch"*)	**Using these four categories, check only the most serious result for each case:** Death (G)	Days away from work (H)	Remained at work: Job transfer or restriction (I)	Remained at work: Other record-able cases (J)	**Enter the number of days the injured or ill worker was:** Away from work (K)	On job transfer or restriction (L)	**Check the "injury" column or choose one type of illness:** (M) Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
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			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
			month/day			❑	❑	❑	❑	____ days	____ days	❑	❑	❑	❑	❑	❑
					Page totals ▶	____	____	____	____	____	____	____ Injury (1)	____ Skin disorder (2)	____ Respiratory condition (3)	____ Poisoning (4)	____ Hearing loss (5)	All other illnesses (6)

Be sure to transfer these totals to the Summary (Form 300A) before you post it.

440-3353A (12/03/COM)

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 ______

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity, or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health-care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in OAR 437-001-0700. Use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (DCBS form 801) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OR-OSHA office for help.

Establishment name: ______

City: ______ State: ______

Identify the person			Describe the case			Classify the case											
						Using these four categories, check only the most serious result for each case:				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness: (M)					
						Death	Days away from work	Remained at work									
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., "welder"*)	(D) Date of injury or of illness	(E) Where the event occurred (*e.g., "loading dock-north end"*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., "second-degree burns on right forearm from acetylene torch"*)	(G)	(H)	Job transfer or restriction (I)	Other record-able cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
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			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
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			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
					Page totals ▶	___	___	___	___	___	___	___	___	___	___	___	___
												Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)

Be sure to transfer these totals to the Summary (Form 300A) before you post it.

440-3353A (12/03/COM)

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 ______

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Establishment name: ______

City: ______ State: ______

Identify the person			Describe the case			Classify the case											
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., "welder"*)	(D) Date of injury or of illness	(E) Where the event occurred (*e.g., "loading dock-north end"*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., "second-degree burns on right forearm from acetylene torch"*)	**Using these four categories, check only the most serious result for each case:**				**Enter the number of days the injured or ill worker was:**		**Check the "injury" column or choose one type of illness:** (M)					
						Death	Days away from work	Remained at work									
								Job transfer or restriction	Other record-able cases	Away from work	On job transfer or restriction	Injury	Skin disorder	Respiratory condition	Poisoning	Hearing loss	All other illnesses
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
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			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	___ days	___ days	☐	☐	☐	☐	☐	☐
					Page totals ▶	___	___	___	___	___	___	___	___	___	___	___	___
												Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)

Be sure to transfer these totals to the Summary (Form 300A) before you post it.

440-3353A (12/03/COM)

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 ______________

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity, or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health-care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in OAR 437-001-0700. Use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (DCBS form 801) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OR-OSHA office for help.

Establishment name: ______________________________

City: ______________________________ State: __________

Identify the person			Describe the case			Classify the case											
(A) Case no.	(B) Employee's name	(C) Job title (*e.g., "welder"*)	(D) Date of injury or of illness	(E) Where the event occurred (*e.g., "loading dock-north end"*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., "second-degree burns on right forearm from acetylene torch"*)	**Using these four categories, check only the most serious result for each case:** Death (G)	Days away from work (H)	Remained at work: Job transfer or restriction (I)	Remained at work: Other record-able cases (J)	**Enter the number of days the injured or ill worker was:** Away from work (K)	On job transfer or restriction (L)	**Check the "injury" column or choose one type of illness:** (M) Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
			month/day			☐	☐	☐	☐	____ days	____ days	☐	☐	☐	☐	☐	☐
					Page totals ▶	____	____	____	____	____	____	____ Injury (1)	____ Skin disorder (2)	____ Respiratory condition (3)	____ Poisoning (4)	____ Hearing loss (5)	All other illnesses (6)

Be sure to transfer these totals to the Summary (Form 300A) before you post it.

440-3353A (12/03/COM)

OSHA Form 300A
Summary of Work-Related Injuries and Illnesses

Year 20 _____

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

All establishments covered by OAR 437-001-0700 must complete this *Summary*, even if no work-related injuries or illnesses occurred during the year. Remember to review the *Log* to verify that the entries are complete and accurate before completing this summary.

Using the *Log*, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the *Log*. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the *OSHA Form 300* in its entirety. They also have limited access to the *DCBS Form 801* or its equivalent. See OAR 437-001-0700(20)

Number of cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfers or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and illness types

Total number of … (M)			
(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Keep this* Summary *posted from February 1 to April 30 of the year following the year covered by this form.

Establishment information

Your establishment name: _____

Street: _____

City: _____ State: _____ Zip: _____

Industry description (e.g., manufacturer of motor truck trailers)

_____

Standard Industrial Classification (SIC) if known (e.g., SIC 3715)

____ ____ ____ ____

Employment information (If you don't have these figures, see the worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that, to the best of my knowledge, the entries are true, accurate, and complete.

_____

Company executive *Title*

Phone: (_____) _____ Date: ____/____/____ _____

Optional: *Worksheet to help you fill out the Summary*

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the *Summary*. If you don't have these figures, you can use the information on this page to estimate the numbers you will need to enter on the *Summary* at the end of the year

How to figure the average number of employees who worked for your establishment during the year:

1 **Add** the total number of employees your establishment paid in all pay periods during the year. Include all employees: full-time, part-time, temporary, seasonal, salaried, and hourly.

The number of employees paid in all pay periods = ❶ _____

2 **Count** the number of pay periods your establishment had during the year. Be sure to include any pay periods when you had no employees.

The number of pay periods during the year = ❷ _____

3 **Divide** the number of employees by the number of pay periods.

❶ / ❷ _____ = ❸ _____

4 **Round** the answer to the next highest whole number. Write the rounded number in the blank marked *Annual average number of employees*.

The number rounded = ❹ _____

For example, Acme Construction figured its average employment this way:

For pay period…	Acme paid this number of employees …	
1	10	Number of employees paid = 830 ❶
2	0	Number of pay periods = 26 ❷
3	15	830 / 26 = 31.92 ❸
4	30	
5	40	
▼	▼	
24	20	31.92 rounds to 32 ❹
25	15	
26	+10	
	830	32 is the annual average number of employees

How to figure the total hours worked by all employees:

Include hours worked by salaried, hourly, part-time and seasonal workers, as well as hours worked by other workers subject to day-to-day supervision by your establishment (e.g., temporary-help-services workers).

Do not include vacation, sick leave, holidays, or any other non-work time, even if employees were paid for it. If your establishment keeps records of only the hours paid or if you have employees who are not paid by the hour, please estimate the hours that the employees actually worked.

If this number isn't available, you can use this optional worksheet to estimate it.

Optional worksheet

_____ **Find** the number of full-time employees in your establishment for the year.

x _____ **Multiply** by the number of work hours for a full-time employee in a year.

_____ This is the number of full-time hours worked.

\+ _____ **Add** any overtime hours and hours worked by other employees (part-time, temporary, seasonal)

_____ **Round** the answer to the next highest whole number. Write the rounded number in the blank marked *Total hours worked by all employees last year.*

OSHA Form 300A
Summary of Work-Related Injuries and Illnesses

Year 20 _____

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

All establishments covered by OAR 437-001-0700 must complete this *Summary*, even if no work-related injuries or illnesses occurred during the year. Remember to review the *Log* to verify that the entries are complete and accurate before completing this summary.

Using the *Log*, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the *Log*. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the *OSHA Form 300* in its entirety. They also have limited access to the *DCBS Form 801* or its equivalent. See OAR 437-001-0700(20)

Number of cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfers or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and illness types

Total number of … (M)			
(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Keep this* Summary *posted from February 1 to April 30 of the year following the year covered by this form.

Establishment information

Your establishment name: _____

Street: _____

City: _____ State: _____ Zip: _____

Industry description (e.g., manufacturer of motor truck trailers)

_____

Standard Industrial Classification (SIC) if known (e.g., SIC 3715)

____ ____ ____ ____

Employment information (If you don't have these figures, see the worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

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I certify that I have examined this document and that, to the best of my knowledge, the entries are true, accurate, and complete.

_____

Company executive *Title*

Phone: (_____) _____ Date: ____/____/____ _____

Optional: *Worksheet to help you fill out the Summary*

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the *Summary*. If you don't have these figures, you can use the information on this page to estimate the numbers you will need to enter on the *Summary* at the end of the year

How to figure the average number of employees who worked for your establishment during the year:

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The number of employees paid in all pay periods = ❶ _____

2 **Count** the number of pay periods your establishment had during the year. Be sure to include any pay periods when you had no employees.

The number of pay periods during the year = ❷ _____

3 **Divide** the number of employees by the number of pay periods.

❶ / ❷ _____ = ❸ _____

4 **Round** the answer to the next highest whole number. Write the rounded number in the blank marked *Annual average number of employees*.

The number rounded = ❹ _____

For example, Acme Construction figured its average employment this way:

For pay period…	Acme paid this number of employees …	
1	10	Number of employees paid = 830 ❶
2	0	Number of pay periods = 26 ❷
3	15	830 / 26 = 31.92 ❸
4	30	
5	40	
▼	▼	
24	20	31.92 rounds to 32 ❹
25	15	
26	+10	
	830	32 is the annual average number of employees

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If this number isn't available, you can use this optional worksheet to estimate it.

Optional worksheet

_____ **Find** the number of full-time employees in your establishment for the year.

x _____ **Multiply** by the number of work hours for a full-time employee in a year.

_____ This is the number of full-time hours worked.

\+ _____ **Add** any overtime hours and hours worked by other employees (part-time, temporary, seasonal)

_____ **Round** the answer to the next highest whole number. Write the rounded number in the blank marked *Total hours worked by all employees last year.*

OSHA Form 300A
Summary of Work-Related Injuries and Illnesses

Year 20 _____

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

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Number of cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfers or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and illness types

Total number of … (M)			
(1) Injuries	_____	(4) Poisonings	_____
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Street: _____

City: _____ State: _____ Zip: _____

Industry description (e.g., manufacturer of motor truck trailers)

_____

Standard Industrial Classification (SIC) if known (e.g., SIC 3715)

____ ____ ____ ____

Employment information (If you don't have these figures, see the worksheet on the back of this page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

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Company executive *Title*

Phone: (_____) _____ Date: ____/____/____ _____

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4	30	
5	40	
▼	▼	
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OSHA Form 300A
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Year 20 _____

Department of Consumer & Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)

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_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and illness types

Total number of …

	(M)		
(1) Injuries	_____	(4) Poisonings	_____
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Standard Industrial Classification (SIC) if known (e.g., SIC 3715)

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Company executive *Title*

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4	30	
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▼	▼	
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25	15	
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_____ This is the number of full-time hours worked.

\+ _____ **Add** any overtime hours and hours worked by other employees (part-time, temporary, seasonal)

_____ **Round** the answer to the next highest whole number. Write the rounded number in the blank marked *Total hours worked by all employees last year.*

OR-OSHA Services

OR-OSHA offers a wide variety of safety and health services to employers and employees:

Consultative services

- Offers no-cost on-site safety and health assistance to Oregon employers to help in recognizing and correcting safety and health problems in their workplaces.
- Provides consultations in the areas of safety, industrial hygiene, ergonomics, occupational safety and health plans, new business assistance, and the Safety and Health Achievement Recognition Program (SHARP).
- Manages the Voluntary Protection Program.

Enforcement

- Offers pre-job conferences for mobile employers in industries like logging and construction.
- Provides abatement assistance to employers with citations and provides compliance and technical assistance by phone.
- Inspects places of employment for occupational safety and health rule violations and investigates workplace safety and health complaints and accidents.

Standards & technical resources

- Develops, interprets, and provides technical advise on safety and health standards.
- Provides copies of all OR-OSHA occupational safety and health standards.
- Publishes booklets, pamphlets, and other materials to assist in the implementation of safety and health standards and programs.
- Operates the OR-OSHA Resource Center containing books, topical files, technical periodicals, a video and film lending library, and more than 200 databases.

Public education & conferences

- Conducts conferences, seminars, workshops, and rule forums.
- Coordinates and provides technical training on topics like confined space, ergonomics, lockout/tagout, and excavations.
- Provides workshops covering basic safety and health program management, safety committees, accident investigation, and job safety analysis.
- Manages the Safety and Health Education and Training Grant Program, that awards grants to industrial and labor groups to develop occupational safety and health training materials for Oregon workers.

For more information, call the OR-OSHA office nearest you.
(All phone numbers are voice and TTY.)

Salem Central Office
350 Winter St. NE, Rm. 430
Salem, OR 97301-3882

Phone: (503) 378-3272
Toll free: 1-800-922-2689
Fax: (503) 947-7461
Spanish-language phone:
1 (800) 843-8086

Portland
1750 NW Naito Parkway, Ste. 112
Portland, OR 97209-2533
(503) 229-5910
Consultation: (503) 229-6193

Salem
1225 Ferry St. SE, U110
Salem, OR 97301-4282
(503) 378-3274
Consultation: (503) 373-7819

Eugene
1140 Willagillespie, Ste. 42
Eugene, OR 97401-2101
(541) 686-7562
Consultation: (541) 686-7913

Bend
Red Oaks Square
1230 NE Third St., Ste. A-115
Bend, OR 97701-4374
(541) 388-6066
Consultation: (541) 388-6068

Medford
1840 Barnett Rd., Ste. D
Medford, OR 97504-8250
(541) 776-6030
Consultation: (541) 776-6016

Pendleton
721 SE Third St., Ste. 306
Pendleton, OR 97801-3056
(541) 276-9175
Consultation: (541) 276-2353

Visit us on the World Wide Web: www.orosha.org

[redacted]

440-3353 (12/03/COM)

[redacted]

SDAO Special Districts Association of Oregon

MEMORANDUM

DATE: May 1, 2009

TO: SDAO Member Districts

FROM: Scott Neufeld, Loss Control Manager
Sandy Galaway, Underwriter

SUBJECT: Risk Management Consulting Services

Thank you for choosing Special Districts Association of Oregon for your Oregon Workers' Compensation coverage. As an SDAO member, we want to make you aware of some free services that are available through our Risk Management Department.

Under Oregon law you are entitled to certain specific services designed to assist you in the identification, evaluation and control of existing and potential causes of accidents, injuries, illnesses and occupational health problems. These free services required by the Self-Insured and Group Self-Insured Employers' Programs (OAR 437-001-1050, OAR 437-001-1055, and OAR 437-001-1060) include:

1. On-site safety and health surveys.
2. Assistance in supervisory training.
3. Providing information on the availability of safety materials.
4. Making recommendations for possible solutions to hazards found in the work place.

You should also be mindful of two other Oregon Administrative Regulations. First, as an employer, you are responsible for providing a safe work environment for all your employees. Second, you are entitled to make a complaint to the Department of Consumer and Business Services, Oregon Occupational Safety and Health Division (OR-OSHA), if we fail to respond to your request for loss prevention services or otherwise fail to provide the above services.

For assistance in any of these areas or for any other occupational safety or health-related questions, please call us at 800.285.5461 or 503.371.8667 in Salem.

Free Loss Control Services for Members

SDAO's Loss Control staff regularly travel the state helping members identify hazards at their districts. Following the visit you will receive a loss control report that identifies the hazards and provides written recommendations for resolving them.

Staff is also qualified to conduct a wide variety of trainings and provide other services for participants in the SDIS workers' compensation insurance program such as:

Trainings

- Accident Investigation
- Adult and Pediatric CPR/First Aid with AED
- Asbestos Awareness Training
- Bloodborne Pathogen
- Confined Space
- Defensive Driving
- Fall Protection Training
- Fire Extinguisher
- Forklift
- General Hazard Identification
- General Lead Awareness
- Hazard Communication
- Hearing Conservation
- Ladder Safety
- Lockout/Tagout
- MRSA (Methicillin Resistant Staphylococcus Aureus)
- PPE (Personal Protective Equipment)
- Safety Committee
- Safety Meetings

Other Services

- Indoor Air Quality Sampling
- Loss Control Inspection
- Noise Sampling
- Online Reference Library
- Safety and Security Matching Grant Program
- Written Safety Plan Review

Loss control services are provided free of charge for participants in the SDIS Workers' Compensation program. If you have the need for a site visit or have any questions about available services, occupational safety, or health-related issues, please contact our Loss Control Department 800.285.5461 or 503.371.8667 in Salem.

Loss Control Manager
Scott Neufeld

Loss Control Consultants
Troy DeYoung
Greg Jackson
Aubrey Sakaguchi
Jeremy Wade

Loss Control Specialist
Bob Ringering

How reimbursement works

Within one year after a worker's participation in the Employer-at-Injury Program ends, the employer submits all insurer-required documentation to the insurer. The insurer requests reimbursement for program costs from the Workers' Compensation Division. To qualify for reimbursement, the insurer must have the following on file:

- Dated copies of the worker's work release(s)
- Documentation of the worker's early return-to-work position
- A copy of the worker's payroll records for the wage-subsidy period
- Copies of receipts for any modifications or Employer-at-Injury Program purchases
- Documentation of the worker's injury-caused obstacles to employment and how the modifications overcame these obstacles, if applicable

Rules governing EAIP

The information in this brochure summarizes the Employer-at-Injury Program. Oregon Administrative Rule 436-105 describes program requirements in further detail. To request a copy of the rules or for additional information about the Employer-at-Injury Program, employers and workers should contact their workers' compensation insurer or the Workers' Compensation Division at 800-445-3948 or 503-947-7588.

For further assistance

The Department of Consumer & Business Services has another program, the ***Preferred Worker Program***, for Oregon employers and workers. The ***Preferred Worker Program*** encourages reemployment of qualified Oregon injured workers. Preferred Workers can offer valuable incentives to employers that hire them. For more information, call 800-445-3948.

Job Match, an online resource, helps employers and Preferred Workers find one another. The Workers' Compensation Division offers free employment-advertising space on its Web site to eligible employers looking for Preferred Workers to fill job openings. The Web site is www.oregonpwp.info. Click on ***Job Match*** to find out more.

Employer-at-Injury Program
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Visit our Web site:
www.oregonpwp.info

440-3525 (4/08/COM)

The Employer-at-Injury Program

Helping employers return injured workers to work

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

All parties benefit when a worker returns to work as quickly as possible after an on-the-job injury

The Employer-at-Injury Program

The Employer-at-Injury Program encourages the early return to work of injured workers. It provides incentives to employers that return their injured workers who have open claims to transitional work.

Employer use of the Employer-at-Injury Program is voluntary. The insurer responsible for the worker's claim administers the program and requests reimbursement for program costs from the Workers' Compensation Division. Reimbursed program costs don't increase employers' insurance costs.

Program reimbursements include wage subsidy, worksite modification, and certain purchases.

Wage subsidy

Fifty percent of a worker's gross wages for a maximum of 66 work days. Reimbursement is based on the return-to-work wage.

Worksite modification

The rental, purchase, or modification of equipment up to a maximum of $2,500 to allow the worker to perform early return-to-work job duties within the injury-related limitations.

Employer-at-Injury Program purchases

Items a worker needs to do the job. Purchases may include:

- Tuition, books, and fees for a course of instruction to update existing skills or to meet the requirements of the job. ***Maximum: $1,000***
- Tools and equipment mandatory for the job that are not already owned by the worker. ***Maximum: $2,500***
- Clothing required for the job that is not normally provided by the employer and not already owned by the worker. ***Maximum: $400***

Worker eligibility

To be eligible for Employer-at-Injury Program incentives, the worker must meet the following criteria:

- Have an accepted, compensable Oregon on-the-job injury or occupational disease
- Not be released for regular work

Employer eligibility

To be eligible for Employer-at-Injury Program incentives, the employer must meet the following criteria:

- Maintain Oregon workers' compensation insurance coverage
- Be the employer at the time of the worker's initial claim or claim reopening
- Reemploy an eligible worker in early return-to-work while the claim is open

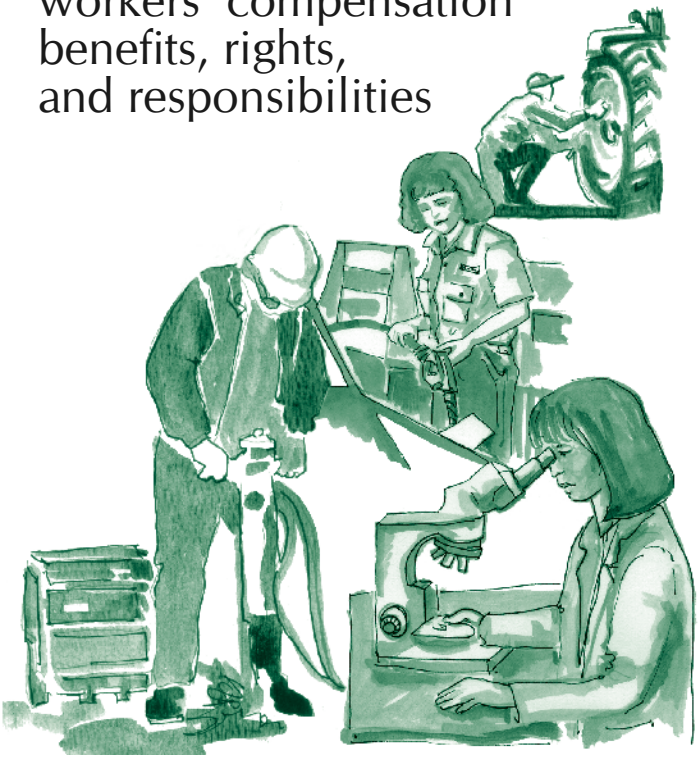
How does an employer use the Employer-at-Injury Program?

The employer contacts the insurer responsible for the worker's claim to ask for help to meet program eligibility requirements and to obtain program assistance. Employers may use program incentives only once for each opening of the worker's claim. The insurer will help the employer:

- Identify an early return-to-work position
- Obtain a qualifying medical release for work from the worker's medical service provider
- Make necessary purchases

What happens if I'm hurt on the job?

A guide to Oregon's workers' compensation benefits, rights, and responsibilities



DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Workers' Compensation Division

December 2007

Get answers to your questions.

Protect your rights —

Stay in touch with your ***insurer***, who is your primary contact. Get the name and phone number of your workers' compensation insurer from your employer.

If you have other questions, call the State of Oregon:

The **Ombudsman for Injured Workers** is the state office that serves as an independent advocate for injured workers by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. The injured worker help line is toll-free: 800-927-1271.

The **Workers' Compensation Division (WCD)** can tell you about workers' compensation rights and responsibilities. WCD answers questions from injured workers, insurers, employers, attorneys, and medical providers. The workers' compensation help line is toll-free: 800-452-0288.

To obtain a copy of this publication in Spanish, call the Workers' Compensation Division: 503-947-7627.

Para obtener una copia de esta publicación en español, llame la División de Compensación para Trabajadores: 503-947-7627.

To obtain a copy of this publication in Russian, call the Workers' Compensation Division: 503-947-7627.

Чтобы приобрести копию публикации на русском языке, пожалуйста, позвоните в Отдел Компенсаций Рабочих (Workers' Compensation Division): 503-947-7627.

To obtain a copy of this publication in Vietnamese, call the Workers' Compensation Division: 503-947-7627.

Muoán coù baûn phoå bieán naøy baèng tieáng Vieät, goïi ñieän thoaïi cho Sôû Boài Thöôøng Lao Ñoäng taïi so: 503-947-7627.

Visit these Web sites —

Ombudsman for Injured Workers
egov.oregon.gov/DCBS/OIW/

Workers' Compensation Division
www.wcd.oregon.gov

In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternative formats. Call the Workers' Compensation Division: 503-947-7810.

Table of contents

Important information

- Throughout this brochure, we use the general term ***"health care provider"*** to describe a person or entity licensed to practice one of the healing arts such as a medical service provider, hospital, medical clinic, or vendor of medical services.
- **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.**

After reading this booklet, if you have additional questions you may contact the insurer, the Ombudsman for Injured Workers, or the Workers' Compensation Division for information about workers' compensation law and rules. You may find contact information in the back of the booklet.

First steps

How do I file a claim?

- If you believe you were injured at work or suffer from an illness because of your job, tell your employer as soon as possible.
- Ask your employer to give you **Form 801, "Report of Job Injury or Illness,"** complete the "worker" portion of the form, and give it back to your employer.
- Your employer will complete their portion and send the form to the workers' compensation insurance company. Your employer will also give you a copy to keep for your records.
- Get the name and phone number of the workers' compensation insurer from your employer. Your insurer is your primary contact, so stay in contact with them.
- Get medical treatment from a health care provider ***of your choice*** and tell your provider that you were injured on the job. Remember: Your employer cannot choose your health care provider for you.
- Your first health care provider should ask you to complete **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims."** The provider will send the form to the insurer and give you a copy for your records.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

How do I get medical treatment?

- You may receive medical treatment from a health care provider ***of your choice*** on the initial claim, including:
  - Authorized nurse practitioner,
  - Chiropractor,
  - Medical doctor,
  - Naturopathic physician,
  - Oral surgeon,
  - Osteopathic doctor,
  - Physician assistant,
  - Podiatrist, and
  - Other health care providers.
- If your claim is accepted, the insurer only has to pay for medical treatment related to the accepted conditions listed on your "Notice of Acceptance."
- If your claim is denied, you may have to pay for your medical treatment.
- The insurance company may enroll you in a ***managed care organization*** **(MCO)** at any time. If you are enrolled in a managed care organization, contact the insurer for more information about your medical treatment options.

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

- Your health care provider must authorize your absence from work. It is recommended a copy of your off-work authorization be provided to your insurer as soon as possible.
- You will not be paid for the first three calendar days for your time off work unless you are off work for 14 consecutive days or hospitalized overnight as an inpatient within the first 14 days.
- If your claim is denied within the first 14 days from the date you reported it to the employer, you will not be paid for any lost wages.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Helpful tips

- Pay attention to information about medical appointments and time limits.
- If you fail to take action or if you miss a deadline to appeal claim decisions, you may lose your right to workers' compensation benefits. If you have questions about your claim or the documents you receive, call the insurer.
- Read all letters and notices about your claim, and keep copies of all letters you send and receive.
- Attend all medical appointments.
- Contact your employer immediately when your health care provider releases you back to work.
- Keep in contact with your doctor and inform your employer about your work restrictions. If your employer offers you a modified job or light duty, you must cooperate with their efforts to return you to work.

Claim status

What is an interim period?

The ***interim period*** begins when your employer first learns you have filed a claim, and it ends when the insurance company determines whether to accept or deny your claim. During the interim period, the insurer will only pay for limited medical treatment. For more information about the types of medical treatment covered during the interim period, see the "Medical Treatment" section on page 10. For more information about time-loss benefits during the interim period, see the "Time-loss (temporary disability) payments" section on page 17.

The insurance company does not have to pay benefits if it denies your claim within 14 days of the date your employer had knowledge or notice of your claim.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

What is acceptance or denial of a claim?

The insurer must accept or deny your claim within 60 days of the day your employer has notice or knowledge of the claim.

- If your claim is accepted, the insurer will send you a "Notice of Acceptance" that lists the specific medical conditions accepted for benefits.
- If you believe the insurer has not listed all the conditions caused by your injury, you must request, in writing, that the insurer add the missing condition(s) to your notice.
- If you believe that the notice is incomplete or incorrect, you must notify the insurer in writing of the error.
- If your claim is denied, the insurer must send you a letter specifying the reason(s) for denying your claim and notify you of your appeal rights.
- If you disagree with the denial, you must request a hearing to protect your rights to the claim.

What if the insurer denies my claim based on an independent medical examination (IME)?

If the insurer denies your claim based on an ***independent medical examination*** **(IME)**, you may be eligible for a ***worker-requested medical examination*** **(WRME),** paid for by the insurer. In order to qualify for a WRME:

- The denial must be based on an IME,
- Your attending physician must disagree with the IME report, and
- You must request a hearing to appeal the denial.

If you meet these conditions and want to request a WRME, or need more information, contact the Workers' Compensation Division at 800-452-0288.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Medical treatment

Do I have privacy rights at medical examinations?

You have the right to privacy at medical examinations. Your employer or the insurer cannot send a representative to your medical examinations without your written consent. If you do not consent, your benefits cannot be stopped or reduced.

What are interim medical benefits?

The interim period begins when your employer first learns you have filed a claim, and it ends when the insurance company determines whether to accept or deny your claim.

During the interim period, the insurer will only pay for the following limited medical treatment:

- Diagnostic services required to identify appropriate treatment or to prevent disability.
- Medication required to alleviate pain.
- Services required to stabilize your claimed condition and to prevent further disability. Examples include, but are not limited to:
  - Antibiotic or anti-inflammatory medication,
  - Physical therapy and other conservative therapies, and
  - Necessary surgical procedures.
- If your claim is denied and you have a health benefit plan (health insurer), give that information to your health care provider and they will work with the health insurer and the workers' compensation insurer to get the bills paid up to the date of the denial.
- If your claim is denied and you ***don't*** have health insurance, you may be responsible for payment of your medical treatment.

Please note: The Oregon Health Plan is not considered a health insurer.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

If you have any questions about your benefits during the interim period, call the workers' compensation insurer for more information.

What medical bills will the insurer pay?

If your claim is accepted, the insurer should pay for:

- Medical treatment related to your on-the-job injury,
- Prescription drugs, and
- Transportation, meals, and lodging necessary to attend medical appointments with some limitations.

Your health care provider should not bill you for medical services. Your provider should bill the workers' compensation insurer directly.

The pharmacy may be able to bill the insurer directly for prescriptions.

If you are required to pay for your prescriptions out-of-pocket, you will have up to two years to send a written request for reimbursement with proof of expenses (copies of receipts) to the insurer.

The insurer has 30 days to reimburse you for your out-of-pocket expenses.

What happens if my claim is denied and my health care provider sends me bills?

If your claim is denied your health care provider is entitled to send you a copy of the bills.

If you appeal your denial, the provider may make no further attempt to collect payment from you until:

- All your appeals are completed, or
- You settle the claim.

If you do not appeal your denial then your health care provider can bill you.

If you have health insurance, the health care provider is required to bill your health insurer.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Who can be my attending physician?

The term "***attending physician***" is used in the workers' compensation system to designate the physician who is responsible for authorizing time-loss benefits and for overseeing the medical care you receive for your work injury. This could include overseeing care from other health care providers, such as physical therapists or other medical specialists, you may have to see in order to recover from the work injury. Under Oregon law, the following health care providers can be attending physicians:

- Medical doctors;
- Doctors of osteopathy;
- Oral or maxillofacial surgeons;
- Chiropractors, podiatrists, naturopathic physicians, and physician assistants who have certified to the director; and
- Medical providers designated to be attending physicians by a managed care organization.

What are the responsibilities of the health care provider?

Attending physicians:

- Authorize time-loss payments if you cannot work,
- Authorize reduced work hours or duties,
- Release you to go back to work, and
- Decide when you are ***medically stationary***.

Emergency room physicians who do not serve as attending physicians may only authorize time loss for 14 days.

Even though chiropractors, podiatrists, naturopathic physicians, and physician assistants can be an attending physician, they:

- May be your attending physician for only up to 60 consecutive calendar days or 18 visits, from the date of your first visit on the initial claim, whichever occurs first.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

- May only authorize time-loss payments for 30 days from your first visit to any chiropractor, podiatrist, naturopathic physician, or physician assistant.
- May not make ***impairment findings***.

Although ***authorized nurse practitioners*** are not designated as attending physicians, they:

- May treat you independently for up to 90 days from the date of your first visit on the initial claim,
- May authorize time-loss payments for up to 60 days,
- May authorize reduced work hours or duties for up to 60 days,
- May release you to go back to work within 60 days,
- May decide when you are medically stationary for up to 90 days, and
- Must refer you to an attending physician for a closing examination if you appear to have permanent impairment.

Providers who do not qualify to be an attending physician or an authorized nurse practitioner:

- May only treat you independently for 30 days or 12 visits from the date of injury, whichever occurs first,
- Are not allowed to authorize time-loss payments or to modify work, and
- Must be authorized by an attending physician or authorized nurse practitioner to provide additional treatment after 30 days or 12 visits.

What if I want to change my attending physician?

Since an attending physician is ***primarily*** responsible for your treatment, you may have only one attending physician at a time.

After your initial choice of an attending physician, you may change attending physicians two more times, by choice. Any further changes need approval from the insurer.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

To change your attending physician, fill out Form 827 at your new attending physician's office, and the attending physician will send the completed form to the insurer.

If the insurer does not approve, you may request approval from the Workers' Compensation Division.

The following are ***not*** considered a change of attending physician:

- A health care provider treats you in an emergency or as an "on-call" physician.
- Your attending physician sends you to a specialist, but remains primarily responsible for your care.
- You change health care providers due to a reason beyond your control such as:
  - Provider's treatment limitations,
  - You or your health care provider move out of the area, or
  - You become enrolled in a managed care organization.

If you are enrolled in a managed care organization, your rights may differ. Contact the insurer to find out more information.

What if my health care provider recommends elective surgery?

Elective surgery is surgery other than emergency surgery. Before scheduling elective surgery, the health care provider must notify the insurer, who may request a second opinion (managed care organization procedures may differ).

If the insurer disagrees about the need for surgery, the insurer must ask the Workers' Compensation Division to review the request for surgery to determine whether the surgery is appropriate.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

What if the insurer enrolls me in a managed care organization?

If your employer is covered by a managed care organization contract, the insurer may enroll you with the managed care organization at any time after your injury. You may be required to select a managed care organization health care provider from a list of providers the insurer sends with your enrollment notice.

Until you are enrolled, any health care provider may provide medical treatment to you up to any treatment limitations they may have.

If you have a regular primary care physician who is a family practitioner, general practitioner, internal medicine specialist, or authorized nurse practitioner, he or she may be able to continue to provide treatment if he or she agrees to treat you according to the managed care organization contract.

What is an independent medical examination?

An independent medical examination is a medical exam of an injured worker by a physician other than the worker's attending physician at the request of the insurer. This doesn't include a consultation arranged by a managed care organization for an enrolled worker.

The insurer may require you to attend up to three medical examinations with health care providers they choose.

You may be penalized $100 or your workers' compensation benefits may be stopped if you fail to attend the exam.

The independent medical examination providers:

- Will not provide treatment.
- Will only prepare a report based on examining you to answer questions asked by the insurance company about your injury or occupational disease.
- May perform a physical- or work-capacity evaluation.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

If the independent medical examination provider intends to perform an invasive procedure (An invasive procedure is one in which the body is entered by a needle, scope, or scalpel):

- They must explain the risks,
- They must obtain your written agreement for this procedure, and
- Your benefits cannot be reduced or stopped if you decline an invasive procedure.

The insurer must pay all costs for the medical examination and will reimburse expenses necessary for you to attend the exam.

If you need advance payment in order to attend, or if you believe you need help attending the appointment because of your work-related injury, contact the insurer as soon as possible.

You may have a family member or friend accompany you to the examination, but the insurer is not required to pay that person's expenses.

To have a friend or family member present during the exam, you must complete, sign, and submit an "IME Observer Form" (440-3923A) to the independent medical provider.

What medical care am I entitled to after I become medically stationary?

When your health care provider determines that neither time nor treatment will improve your condition, you are considered medically stationary.

Medical benefits after you are found to be medically stationary may be limited to:

- Prescription drugs,
- Diagnostic care, and
- Life preserving treatment.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

Contact the insurer or the Workers' Compensation Division if you have questions about covered services.

Palliative care, a medical service that makes you feel better but doesn't heal your condition, is covered if you are working and need the care to continue working or attend vocational training. The care is covered only if approved by the insurer or the Workers' Compensation Division.

What is a new or omitted medical condition?

A new condition is a condition that arises from the original injury. An omitted condition is a condition that was always there since the injury but was not accepted by the insurer. A worker may request the insurer to accept either a new or omitted condition at any time after the injury. That right continues even after your ***aggravation rights*** expire.

Time-loss (temporary disability) payments

If I miss time from work, will I get paid?

- If your health care provider authorizes you to take time off work or to do modified work that causes you to lose wages, you will receive time-loss payments from the insurer.
- Your first check will be mailed within 14 days from the date the insurer receives authorization from your health care provider.
- No compensation is due for time missed from work that has not been authorized by your health care provider.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

If you are unable to work, remind your health care provider each time you see him or her to send your time-loss authorization to the insurer. You can help ensure timely payments by contacting the insurer as soon as you begin to miss work.

Time-loss benefits will ***stop*** if one of the following happens:

- Your health care provider fails to provide time-loss authorization,
- Your claim is denied,
- Your health care provider gives you a release to return to regular work,
- You return to regular work at full wages,
- A Notice of Closure closes your claim,
- You are incarcerated (incarcerated means in pretrial detention or in prison following conviction for a crime), or
- You remove yourself from the workforce.

Time-loss benefits will also be ***reduced or stopped*** if one of the following happens:

- Your health care provider approves a written offer of modified work and you refuse to take the job.
- Your health care provider approves work with your employer and your employer fires you (with cause).
- Your health care provider releases you to work, but you are unable to work because you are in the United States in violation of federal immigration laws.

Is there a waiting period to receive benefits?

Oregon has a three-day waiting period for benefits. You will not be paid for the first three calendar days for your time off work unless you are off work 14 days in a row, or you are hospitalized overnight as an inpatient within the first 14 days.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

The first day you lose time or wages will be the first day of the three-day waiting period.

If you are released for modified duty during the first 14 days, you will ***not*** be paid for the three-day waiting period.

How do you calculate wages to determine payments?

Payment for time lost from work is called ***temporary total disability*** or ***temporary partial disability*** and is based on your average weekly wage at the time of injury. The insurer may calculate your average weekly wage by averaging the wages you earned over the 52 weeks before your injury.

- To receive payments for ***supplemental disability*** you must have had more than one job at the time of injury. You may be eligible to receive payments for time lost from the other jobs.
- You must let the insurer know about your other jobs within 30 days of the day you filed the claim.
- To receive payment for any time lost from those other jobs, you must provide check stubs or payroll records as proof of how much you earned.
- Time-loss payments will equal two-thirds of your gross average weekly wage.
- Oregon has a minimum and maximum amount payable to an injured worker that is adjusted every year.
- If your doctor returns you to modified or light duty work and you earn less money, you may be eligible to receive partial time-loss payments.
- Your average weekly wage is an important factor in calculating your time-loss benefits and it is important to verify your proper wage is being used in these calculations.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Returning to work

What are my rights when returning to work?

Most Oregon employers with more than 20 workers are required to return an injured worker to the worker's job or another suitable job after the worker is released to work.

- The insurer will send you written notice when your health care provider releases you to go back to work.
- When you receive this notice, you must ask your employer for your job or another suitable job within ***seven calendar days*** (sooner if your union contract or employer's personnel policies require it), or you will lose your right to be reinstated with your employer.
- When you receive any release for work, take it to your employer as soon as possible, as work may be available that is physically appropriate for you.

If you have questions about your rights or believe your employer has treated you unfairly because of your injury, call the Bureau of Labor and Industries, 971-673-0761 in the Portland area, or 541-686-7623 outside the Portland area.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

Are there benefits in staying at work or returning to work?

Research shows that injured workers benefit from returning to work ***at the earliest possible time*** after an on-the-job injury.

Staying at work or returning to work as quickly as possible helps you prevent financial loss. When your health care provider manages your return to work, it can also help you recover from your injury faster.

What is modified work?

If your employer offers you modified work, contact your health care provider to find out if you are physically able to do the job. If your health care provider says you can do the modified job offered by your employer, you must accept the job or your time-loss benefits may be reduced or stopped. If you find after returning to work that you cannot do the job because of your injury, contact your health care provider immediately.

If you return to modified or light duty work at a lower rate of pay or fewer hours, you will receive time-loss payments for the part of your wages you are missing. You may refuse a modified job without ending your time-loss benefits if ***any*** of the following is true:

- The job is ***not*** with the employer at injury or at a job site of the employer at injury (exception for home care workers per House Bill 3362).
- Your health care provider says you are physically unable to commute to the job site. (Your commute is the distance from your residence to your job at injury, or the distance to the job you are offered as modified work.)
- The job site is more than 50 miles from where you customarily worked before your injury, unless that job site is less than 50 miles from your home.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

However, greater distance may be appropriate if the employer has multiple or mobile job sites and prior to the injury you could have been assigned to any such site.

- The job's work schedule (shift) differs from the employer's written policy for changing work schedules, the common practice of the employer, or collective bargaining agreement.

What reemployment assistance is available from the Workers' Compensation Division?

The Employer-at-Injury Program helps workers stay on the job or get back to work with the employer at injury. Because of your injury, your employer may be eligible for benefits to assist in returning you to light-duty work while your claim is open.

The Preferred Worker Program helps injured workers get back to work by providing benefits to the employer-at-injury or any other Oregon employer. If you have permanent disability due to your injury, and your health care provider says you can't return to your regular job, you may qualify as a preferred worker.

If you are eligible for the Preferred Worker Program, you will receive an identification card and program materials shortly after your claim is closed.

If you think you should be eligible for Preferred Worker Program benefits and don't get an identification card soon after your claim is closed, call toll-free at 800-445-3948 or 800-696-7161 in Medford to ask whether you are eligible.

If you have questions or want to learn more about the Preferred Worker Program, contact a program representative toll-free at 800-445-3948 or 800-696-7161 in the Medford area.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

Do I qualify for vocational assistance?

Vocational assistance includes help with job placement and training. You may qualify for assistance if as a result of your accepted condition, ***all*** of the following are true:

- You have permanent disability,
- You cannot return to your regular job or a job that pays at least 80 percent of the wage you were earning, and
- You are authorized to work in the United States.

Within 35 days of when you become medically stationary, the insurer will determine if you are eligible for vocational assistance and notify you of its decision in writing. Contact the insurer if you need help getting back to work.

If you have questions, you may call the Workers' Compensation Division toll-free at 800-452-0288 or 800-696-7161 in the Medford area.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Claim closure

What is a Notice of Closure?

Disabling claims are "open" or "active" while you are recovering from your injury and "closed" or "inactive" when you are medically stationary.

Your claim will also be closed if your injury is no longer the major cause of your disability or need for treatment, or if you fail to attend medical appointments. The insurer will send you the following important documents when your claim is closed:

- A legal document called a "Notice of Closure" that closes your claim. It lists the periods for which time-loss benefits were authorized and tells you how much permanent disability you may have. This document also tells you how to appeal the closure of your claim.
- An "Updated Notice of Acceptance at Closure" that lists the medical conditions the insurer has accepted. If the updated notice is incomplete or incorrect, notify the insurer in writing.
- A brochure, "Understanding Claim Closure and Your Rights," explaining your appeal rights and the types of care covered by the insurer after claim closure.

After your time-loss payments end, you may be entitled to unemployment benefits (even if it would ordinarily be too late to qualify). You must apply within four weeks of the date of the notice ordering claim closure to see if you qualify for a special "base-year extension," available to some injured workers. Contact the Oregon Employment Department office in your area for more information.

What is permanent partial disability (PPD)?

If the Notice of Closure shows you have ***permanent partial disability***, this means your injury resulted in a condition that has not returned to its normal or pre-injury status.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

You may be entitled to receive payment from the insurer for your disability. Permanent disability payments are based on a formula set by law. The amount will depend on the severity of the disability and whether you received overpayment of benefits. If the insurer overpaid you for benefits while your claim was open, the insurer may recover the overpayment by reducing your permanent disability payment or by reducing future benefits. Here are some things to keep in mind about permanent partial disability benefits:

- Permanent disability award payments are due to start 30 days from the mailing date of the closure.
- If your award is $6,000 or less, the insurer will pay you a lump sum.
- If your permanent partial disability award is more than $6,000, the insurer will make monthly payments to you until the award is paid. Your monthly award payments are equal to your monthly temporary total disability rate.
- You may ask the insurer to pay you a ***lump sum***. However, if you or the insurer appeals the amount of your permanent disability award, you cannot receive a lump-sum payment until the appeal process is finished and the order is final. **If you apply for and accept lump-sum payment of any part of your permanent disability award, you give up your right to appeal the amount of the award**. You are not eligible to receive your payment in a lump sum if you are enrolled and actively engaged in a vocational training program.

What is permanent total disability (PTD)?

If the Notice of Closure shows you have ***permanent total disability***, it means you are permanently unable to perform gainful and suitable employment. You will receive monthly disability payments as long as you remain totally disabled. The insurer will reexamine your claim at least every two years to see if you remain unable to work.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

What are fatality benefits?

When a worker dies due to an on-the-job injury or occupational disease or illness, and the insurer accepts the claim, Oregon law requires insurers to make monthly payments to the worker's spouse, children, and other eligible beneficiaries, and to pay burial expenses. If you die while receiving permanent total disability benefits, your spouse or other eligible beneficiaries may be entitled to continuing benefits.

What do I do if I disagree with the Notice of Closure?

If you disagree with the Notice of Closure, you must write to the Workers' Compensation Division within 60 days of the mailing date printed on the Notice of Closure. Your appeal rights and the address to send your appeal are printed on the back of the Notice of Closure.

You may also fill out and send the form "Worker's Request for Reconsideration" to the Workers' Compensation Division. You can obtain the form by contacting the division and asking for a copy of the form to be mailed to you, or going to the division's Web site, ***www.wcd.oregon.gov***. Click on "Forms," then click "Forms by category." Select "Requests to the Workers' Compensation Division for review of a decision or resolution of a dispute." The Worker's Request for Reconsideration, Form 2223A, is available in several formats for you to download, print, and fill out. For more information or assistance, call the Workers' Compensation Division at 800-452-0288 and ask to speak with an appellate reviewer.

What if my accepted condition gets worse?

If your accepted condition gets worse after your claim is closed, you have the right to seek medical care. You may ask the insurer to reopen your claim by filing a Form 827 at your attending physician's office. The health care provider will submit the paperwork to the insurer on your behalf.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

Aggravation rights on disabling claims expire five years from the first closure date of the claim. Aggravation rights on a nondisabling claim expire five years from the date of injury.

After the five-year rights expire, you may still have some rights to additional benefits. If you need hospitalization, surgery, or other curative treatment in lieu of hospitalization, the insurer may reopen the claim and pay time-loss benefits that are authorized by the attending physician until your conditions are again declared medically stationary.

If you request acceptance of a new or omitted medical condition after your aggravation rights expire, you may also be eligible to receive a permanent disability award if your condition has permanently worsened more than when your claim was last closed.

Appeal rights and claim settlements

What if I disagree with a decision?

You can appeal any decision made about your claim. An "appeal" is a request by an injured worker, an insurer, or another party to a claim for a review of a decision made about the claim. If you receive a notice that your claim or benefits are denied or ended, the document you receive will have instructions on how to appeal if you disagree with the decision. **There are time limits for most appeals. You'll lose your appeal rights if you don't appeal within the limits as printed in the letter you received.** Benefits that are the subject of the appeal are usually not paid until the appeal process (***litigation***) is completed. If you want legal advice, check the yellow pages of your phone directory under "Attorneys" or call the Oregon State Bar, 800-452-7636, to find a lawyer who handles workers' compensation cases in your area.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

What is a disputed-claim settlement?

If you and the insurer disagree about whether you have a valid workers' compensation claim or condition, you and the insurer may resolve the disagreement by a ***disputed-claim settlement***.

A disputed-claim settlement (DCS) is settlement of a claim when there is a disagreement about compensability. In a DCS, for an agreed upon sum of money, you release all rights and benefits associated with the claim. This means your claim will remain denied, and you will give up all rights to future benefits for the denied medical conditions of the claim.

Health care providers may bill you for services not paid by the insurer, so be sure to know what your obligations will be under the agreement before you agree to a settlement.

What is a claim disposition agreement?

If you have an accepted claim, you may exchange your rights to the claim for money through a ***claim disposition agreement***. In such an agreement you may give up your rights to one or more of the following claim benefits:

- Present and future time-loss benefits.
- Present and future permanent partial disability awards.
- Monthly payments for permanent total disability.
- Vocational assistance benefits.
- Aggravation rights to reopen your claim.
- Survivor benefits.

However, you cannot give up your right to medical benefits or your eligibility for the Preferred Worker Program.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services Directory, Page 34.

The Workers' Compensation Board must approve all claim disposition agreements unless the settlement was negotiated during a mediation. In this instance the administrative law judge who mediated the dispute can approve the settlement document. If you have a question about the claim disposition agreement, you may contact the Ombudsman for Injured Workers at 800-927-1271.

What are penalties for late payment?

If you believe that the insurer delayed accepting or denying your claim or delayed payment of benefits past their due date, you may write to the Workers' Compensation Division and request that the insurer be penalized. If the Workers' Compensation Division finds that a penalty is appropriate, the insurer will pay the penalty amount to you and your attorney if you are represented.

Are my records confidential?

Claim information on file with the Workers' Compensation Division and medical and vocational claim records on file with the insurer may be released only in limited circumstances, such as:

- When you or your attorney requests copies,
- When necessary for the insurer to process your claim,
- When necessary for government agencies to carry out their duties, or
- When otherwise required or allowed by law.

Employers may not legally consider workers' compensation injuries in making their hiring decisions.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Glossary of workers' compensation terms

In this booklet, you will find the following terms:

aggravation claim: A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. An aggravation is established by medical evidence supported by objective findings observed or measured by the physician. **Aggravation rights** expire five years after first closure on disabling claims or five years from date of injury on nondisabling claims. An attending physician who is a doctor of medicine, doctor of osteopathy, or oral and maxillofacial surgeon, must file a Form 827 and a medical report with the insurer within five consecutive calendar days of the worker's visit to make a claim for aggravation. The insurer has 60 days to accept or deny a claim for an aggravation. ORS 656.273.

attending physician (AP): A doctor or physician who is primarily responsible for the medical care of a worker by either directly treating the worker or by approving and directing care provided by others to the worker. The attending physician must be a licensed medical doctor, doctor of osteopathy, oral and maxillofacial surgeon, or medical provider designated to be an attending physician by the managed care organization (MCO). A chiropractor, podiatrist, naturopathic physician, or physician assistant on the WCD health care provider certification list can be an attending physician for up to 60 consecutive calendar days or 18 visits (whichever occurs first) and authorize time-loss benefits for up to 30 calendar days from the first day the patient sees any provider on the WCD health care provider certification list. ORS 656.005

authorized nurse practitioner: A nurse practitioner authorized by the Workers' Compensation Division may provide compensable medical services to an injured worker for a period of 90 consecutive calendar days from the date of the first nurse practitioner visit on the initial claim. A nurse practitioner may also authorize the payment of temporary-disability benefits for a maximum of 60 calendar days from the date of the first nurse practitioner visit on the initial claim. Authorized nurse practitioners cannot make impairment findings. Nurse practitioners authorized to treat by managed care organizations may treat longer than 90 days. ORS 656.245

claim disposition agreement (CDA and C&R): An agreement between the parties to a workers' compensation claim. For an agreed upon sum of money, the worker agrees to sell back his or her rights (e.g., rights to compensation, attorney fees, and expenses) except rights to medical benefits or preferred worker benefits on an accepted claim. Also known as a "C&R" or a "compromise and release."

disabling injury: An on-the-job injury that entitles the worker to disability compensation or death benefits. ORS 656.005

disputed-claim settlement (DCS): Settlement of a claim when there is disagreement about compensability. For an agreed upon sum of money, the worker releases all rights and benefits associated with the claim.

employer knowledge date (EKD): The date on which an employer has knowledge of a workers' compensation claim.

health care provider: A person or organization duly licensed to practice one of the healing arts such as a medical service provider, a hospital, medical clinic, or vendor of medical services.

impairment findings: A measurement, by a physician, of loss of use or function of a body part or system.

independent medical examination (IME): Any medical examination including a physical capacity or work capacity evaluation, or consultation that

includes an examination that is requested by the insurer and completed by a medical service provider other than the worker's attending physician.

injury: An on-the-job injury (a sudden and discrete event) or occupational disease.

interim period: The time between when an employer first has knowledge or notice about a claim and when the insurance company accepts or denies the claim.

insurer: An insurance company, self-insured employer, or self-insured employer group that provides workers' compensation coverage to employers and benefits to injured workers.

litigation: A process that usually results in a judge deciding the resolution of the dispute based on the facts and the law.

lump sum: The payment of a permanent partial disability award in one check (for awards that are more than $6,000) usually upon request of the worker. Awards that are less than $6,000 are always paid in a lump sum.

managed care organization (MCO): An organization that contracts with an insurer to coordinate medical services to injured workers. ORS 656.260

medically stationary: An injured worker is considered medically stationary when the attending physician determines no further significant improvement to the worker's condition that resulted from the injury or illness can reasonably be expected either from medical treatment or the passage of time. ORS 656.005

nondisabling injury: Any injury that requires only medical services with no inability to work beyond the first three days and does not result in any measurable permanent disability. ORS 656.005

occupational disease: A disease or infection resulting from a worker's job. It is caused by substances or activities an employee is exposed to at work and results in medical services, disability, or death. ORS 656.802

Ombudsman for Injured Workers: The Department of Consumer and Business Services office that serves as an independent advocate for injured workers by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. ORS 656.709

permanent partial disability (PPD): The permanent loss of use or function of any portion of the body as defined by ORS 656.214.

permanent total disability (PTD): The loss of use or function of any portion of the body in combination with any pre-existing disability that permanently prevents the worker from regularly performing gainful and suitable work. ORS 656.206

supplemental disability: The increase of disability payments due a worker employed in more than one job at the time of injury.

temporary partial disability benefits (TPD): Payment for partial loss of wages when a worker can work only part time or light duty after an injury. ORS 656.212

temporary total disability benefits (TTD): Payment for loss of all wages after an injury when the worker can't return to any work. ORS 656.210

time-loss payments: Payments to an injured worker who loses time or wages because of a compensable injury. ORS 656.210

Workers' Compensation Board (WCB): The part of the Oregon Department of Consumer and Business Services responsible for conducting hearings and reviewing legal decisions and agreements affecting injured workers' benefits.

Workers' Compensation Division (WCD): The division within the Oregon Department of Consumer and Business Services that administers the state's workers' compensation laws.

worker-requested medical exam (WRME): An examination available to a worker whose claim has been denied based on an independent medical exam where the injured worker's physician does not concur with the findings.

Services Directory

Visit one of the following state of Oregon Web pages for more information:

Workers' Compensation Division
www.wcd.oregon.gov

Ombudsman for Injured Workers
egov.oregon.gov/DCBS/OIW/

Workers' Compensation Board
www.wcb.oregon.gov

Workers' Compensation Division

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

General information 503-947-7810

Workers' Compensation Infoline 800-452-0288
or send e-mail to: workcomp.questions@state.or.us

Benefits information 503-947-7585
or 800-452-0288

WCD Employer Index
(to verify employer's insurance) 888-877-5670

Investigations — Fraud Hotline 800-452-0288

Managed care organization
(MCO) questions 503-934-6049

Medical fee, medical treatment, curative care, palliative care disputes, and interim medical benefits 503-934-6049

Reconsideration of claim closures 503-947-7816

Reemployment assistance 503-947-7588
or 800-445-3948

Medford region 800-696-7161

Vocational eligibility/assistance, return-to-work plans, and vocational disputes 503-947-7816

Ombudsman for Injured Workers

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
..... 503-378-3351
Injured Worker Infoline 800-927-1271

Workers' Compensation Board (WCB) (and Hearings Division)

2601 25th St. SE, Suite 150
Salem, OR 97302-1282
.....503-378-3308

Other resources

This booklet explains workers' compensation benefits. Even if your claim has been denied or you have exhausted your workers' compensation benefits, you may be eligible for some other types of assistance.

- Contact the Oregon Employment Department to find out if you are eligible for unemployment benefits.
- Contact the Social Security Administration to find out if you are eligible for disability benefits.
- Contact the Oregon Office of Vocational Rehabilitation Services to find out if you are eligible for rehabilitation services.

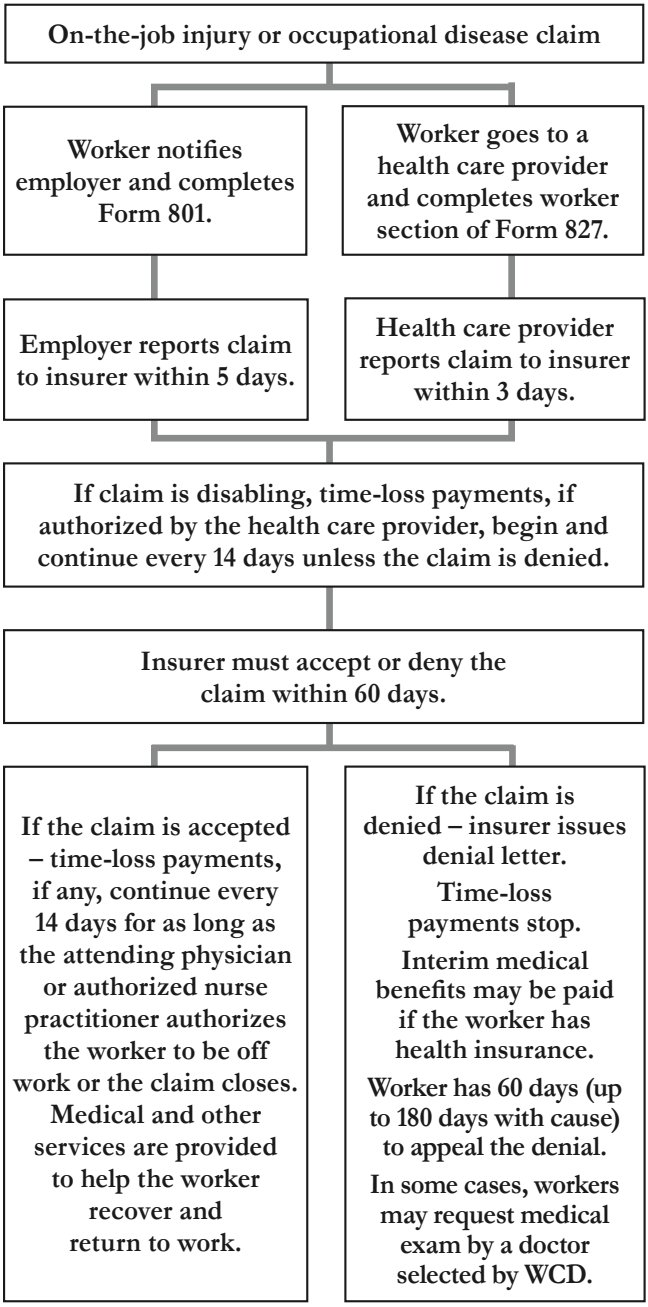
If you have any other questions about your benefits, contact the Ombudsman for Injured Workers, 800-927-1271, or the Workers' Compensation Division, 800-452-0288.

If you have questions about injured workers' employments rights, contact the Civil Rights Division, Bureau of Labor and Industries (workers' compensation discrimination issues):

971-673-0761 in Portland,
541-686-7623 in Eugene,
503-378-3292 in Salem.

Workers' Compensation Claim Process

From injury through acceptance or denial:



From acceptance through closure and beyond:

Worker and insurer may make a claim disposition agreement (at any time after claim acceptance), subject to approval by the Workers' Compensation Board.

The claim will be closed when the worker is medically stationary.

The claim is closed and a decision is made about the amount of worker's disability, including permanent partial disability (PPD), if any. A Notice of Closure is issued by the insurer.

Vocational assistance is provided if worker is eligible (at any time after claim acceptance).

If worker cannot return to regular work and has permanent disability, WCD issues a Preferred Worker Card, which allows worker to offer hiring incentives to Oregon employers.

Insurer (within 30 days of the notice of closure) must begin payment of PPD, if any. However, if the claim closure is appealed, payment may be stayed (not paid) until the litigation is completed.

Insurer, within seven days, or worker, within 60 days of claim closure, may request reconsideration by the WCD Appellate Unit.

After the claim is closed, worker remains eligible for certain medical and vocational services. If the accepted condition worsens, the claim may be reopened for additional disability and other benefits.

Oregon Department of
Consumer & Business Services
Workers' Compensation Division
350 Winter St. NE,
P.O. Box 14480
Salem, OR 97309-0405
800-452-0288

440-1138 (12/07/COM)

Name & Address (optional)

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 1266 SALEM OR

POSTAGE WILL BE PAID BY ADDRESSEE

WORKERS' COMPENSATION DIVISION - POLICY & COMMUNICATIONS
DEPARTMENT OF CONSUMER & BUSINESS SERVICES
P.O. BOX 14480
SALEM OR 97309-0405

Please complete this card and keep it with you so you have access to claim information at all times.

Claim Information Record

Insurer:	Phone:
Insurer representative:	
Claim no.:	Date of injury:
Attending physician:	
Employer's name:	

Keep this card with you so you have access to claim information at all times.

Dear reader,

The Oregon Workers' Compensation Division provides this booklet to Oregon workers with disabling claims. Please let us know if it is useful and if you have suggestions for improvements. Write your comments in the space below, and drop this card in the mail — no postage necessary. Thank you.

Comments: _____

_____

_____

_____

If you would like the Workers' Compensation Division to contact you, please print your name and address on the reverse side and provide your phone number: (____) _____

440-3138 (11/07/COM)

Service Directory

Workers' Compensation Division

General information	503-947-7810
Workers' Compensation Infoline	800-452-0288
Benefits information (see also Ombudsman)	503-947-7585
Employer index (to verify employer's insurance)	888-877-5670
Investigations - fraud hotline	800-452-0288
Reemployment assistance	800-445-3948
Medford region	800-696-7161
Medical and vocational disputes: Reconsideration of claim closure	503-947-7816
Workers' Compensation Board	503-378-3308
Ombudsman for Injured Workers	503-378-3351
Injured Worker Helpline	800-927-1271

Web address: www.wcd.oregon.gov

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.
- 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.
- 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.**

440-3283 (1/07/DCBS/WCD/WEB)

SDIS – SELF-INSURED EMPLOYERS GROUP
P.O. Box 23879
Tigard, OR 97281-3879
(503) 670-7066 / 1-800-305-1736
Fax (503) 620-6217

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 / Part
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)				Ev / Src / 2src
Name of Witnesses:	Have you previously injured or sought treatment for this body part? ☐Yes ☐No			

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: / Dept. & Job Title:	Work phone:	
Name of your primary care physician:	If medical treatment was not with your primary care physician, 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. I authorize the release of 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. **I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.**

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:
Workers shift on day of injury: (from) _____ ☐ a.m ☐ p.m. (to) _____ ☐ a.m ☐ p.m.		
Worker's weekly wage: Per ☐ Hr. ☐ Day ☐ Wk. ☐ Mo ☐ Yr $_____	Give total weekly wage and explain if wage prior to injury varied or included other earnings (tips, room and board, commission, etc.) Attach 52 weeks of payroll records.	
Return-to-work status ☐ Not returned ☐ Regular Date: ☐ Modified Date:	If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No	
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		NCCI code:
Were other workers injured? ☐Yes ☐No	OSHA 300 log case #:	

Date employer knew of claim:	Person claim reported to:	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) 3789-3272, or Oregon Emergency response (800) 452-0311, on nights and weekends.

801

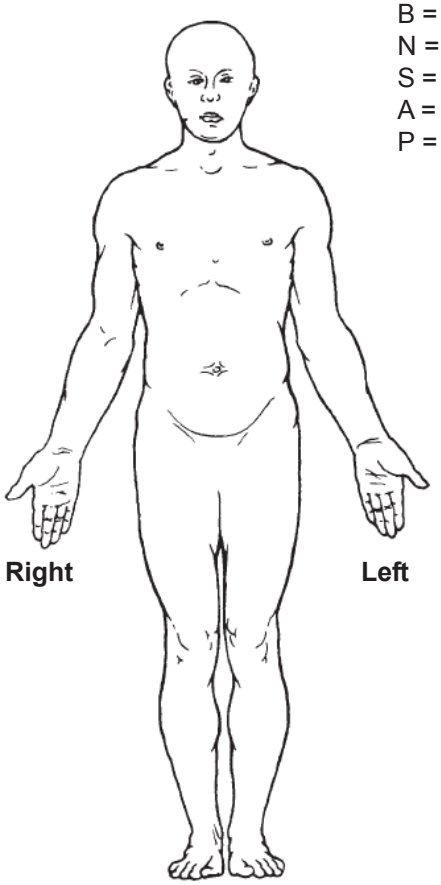
Pain Diagram

This Pain Diagram needs to completed and submitted with either an **Incident Report**, an **801 Form**, or both. Mail originals to SDAO, PO Box 23879, Tigard OR 97281. Please retain a copy for your own records.

Name:_____ Employer:_____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

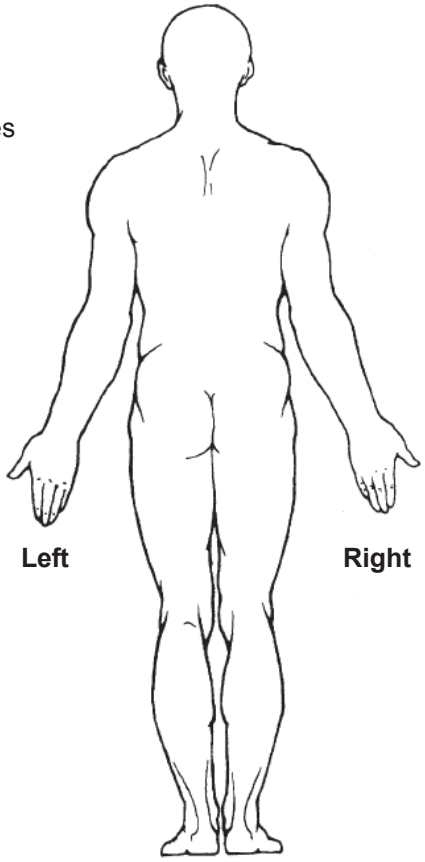
Front



Right **Left**

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Left **Right**

	0 = No Pain			**Pain Scale**							*10 = Severe Pain*
Circle one:	0	1	2	3	4	5	6	7	8	9	10

Please use the space below to describe your condition further, if needed: _____

_____

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: _____

Worker's Signature: _____ Date: _____