

## EMPLOYEE INSTRUCTIONS FOR INCIDENT ANALYSIS REPORT / WORKERS COMPENSATION 801

<b>Employee Responsibility</b>	<b>1. Complete the Incident Analysis Form</b>	Complete online form providing as much detail on what happened as possible, and contact immediate supervisor/designee by the end of the work day of the incident.
		This form is accessed via the internet/ using Mozilla Firefox browser. Use the following instructions to access the Incident Analysis Reporting system.
		a. Go the MESD Home Page
		b. Access the 'Online forms' and log on.
		c. Click "Forms" in the upper left-hand corner.
		d. Click "New Employee Safety Incident" to access a blank reporting form. Fill out the report being careful to fill in all applicable fields.
		e. Click on "Send to Supervisor" to complete.
		f. Contact supervisor when form is completed.
		g. If you have problems or questions contact your supervisor or HR WC Specialist in HR at 503-257-1512.
	<b>2. Complete an 801 Form</b>	If the incident warrants a visit to the doctor the employee must also complete #1 through #28 of Form 801 and give it to immediate supervisor within 3 days of the visit to the doctor. For assistance call HR WC Specialist 503-257-1512. Please do not pony the form.
		How to Access the 801 Packet
		a. Go to the MESD Home Page
		b. Click on "Human Resources Dept"
		c. Search under MESD EMPLOYEE RESOURCES and select "Forms for Employees"
		d. Click on Work Injury/801 Packet and print packet that includes forms and information.
	<b>3. Return to Work Information Form</b>	This form is included in the 801 packet. Take the attached Return to Work Information form to your doctor and fax to 503-257-1715, HR Secured Fax. Report any work duty restrictions from your doctor to HR WC Specialist at 503-257-1512. Do not miss your follow up appointments. Keep the HR WC Specialist informed of your progress. Provide HR with doctor's report from each visit, including a release to regular duty. Do not Pony form.

## SUPERVISOR INSTRUCTIONS FOR INCIDENT ANALYSIS REPORT / WORKERS COMPENSATION 801

<b>Supervisor Responsibility</b>	<b>1. Complete the Incident Analysis Form</b>	Analysis should commence within 24 hours of incident and conclude as soon as possible. You will receive notification via employee or email when the employee has completed the online Incident Analysis form.
		This form is accessed via the internet/ using Mozilla Firefox browser. Use the following instructions to access the Incident Analysis Reporting system.
		a. Go the MESD Home Page
		b. Access the 'Online forms' and log on.
		c. Click on "Admin" in the upper middle menus of the forms page.
		d. Click on "Safety Admin" in the left menu. That will bring up the "Summary of Current Safety Incidents" list..
		e. Click on "start" in the analysis column to begin updating the employee form.
		f. Note the receiving date and assign a claim code and nature.
		g. Completely fill out the analysis section of the incident report.
		h. Click "Submit Completed Analysis"
		i. An email alert will be sent to HR notifying them of the availability of this incident report.
	<b>2. Complete an 801 Form</b>	After completing the incident analysis report, the supervisor is to follow-up to see if the incident warrants a doctor visit and if so, be sure the employee submits Form 801 within 3 working days of the doctor visit. Supervisors are to complete #38, 39, 41, 42, 44, 48, 50, 51, 52 and submit to Human Resources within 3 days of injured worker seeing doctor. Human Resources will complete 801 #29 through #37, and #40, 43, 45. 46, 47, and 49. For assistance call HR WC Specialist at 503-257-1512. Do Not Pony Form.

## Employee Identification Form

**Notice To Employee:**

Take this ID form and the attached Return to Work Information form to the medical provider or professional if you seek medical treatment for an on-the-job injury or illness

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date of Injury

\_\_\_\_\_  
Social Security Number

**Notice to Doctor:**

Employer: Multnomah Education Service District  
Attn: WC - HR Specialist  
11611 NE Ainsworth Circle  
Portland, OR 97220  
Phone: 503-257-1512  
Fax: 503-257-1715

Insurer: SAIF Corporation  
400 High Street S.E  
Salem, OR 97312-1000  
Phone: :503-373-8000 or 1-800-285-8525  
Fax 1-800-475-7785

WCD Number 5622303  
Policy Number 487589

BIN: 503258-2

NOTE: Please complete the attached return to work form to update us on your patient's work abilities and return it with the employee.

# RELEASE TO RETURN TO WORK

Name of worker	Claim number
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**Please complete at appointment and return to injured worker .**

1. Is the worker medically stationary?	<input type="checkbox"/> Yes	Date: _____	Provide closing information & complete Form 827.
	<input type="checkbox"/> No	Next scheduled appointment date: _____	
2. Worker is released to:			
<input type="checkbox"/> full duty without limitations	Date	(Do not complete #3 through #12 — sign below.)	
<input type="checkbox"/> modified duty from (date)	through (date) specify limitations below	Number of hours per day worker is released to work: _____ hours/day _____	
<input type="checkbox"/> modified hours ----specify	from (date)	through (date) _____	

	Hours: limitations	1	2	3	4	5	6	7	8
3. In an eight-hour workday, worker can stand/walk a total of		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. At one time, worker can stand/walk.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In an eight-hour workday, worker can sit a total of.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. At one time, worker can sit.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Worker can use hands for repetitive:

	Right	Left	
a. Fine manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant hand <input type="checkbox"/> Right <input type="checkbox"/> Left
b. Pushing and pulling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Simple grasping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Keyboarding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crouch-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Crawl-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Kneel-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Twist-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Climb-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Balance-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reach-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Push/pull-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Other functional limitations or modifications necessary in worker's employment (impairing medications, vision, etc):

**(Additional comments may be written on back of form)**

Signature of physician	Physician's typed name	Date
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**For SAIF Customer Use**

Area \_\_\_\_\_  
 Dept. \_\_\_\_\_  
 Shift \_\_\_\_\_ CC \_\_\_\_\_

CLAIM NO. \_\_\_\_\_  
 SUBJECT DATE \_\_\_\_\_  
 CLASS \_\_\_\_\_  
 DEFAULT DATE \_\_\_\_\_  
 EMPLOYER'S ACCOUNT NO. \_\_\_\_\_

Toll-free phone: 1.800.285.8525

Toll-free FAX: 1.800.475.7785

**Report of Job Injury  
 or Illness**

Workers' compensation claim

**Worker**

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness:	2. Date you left work:	3. Time you began work on day of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	4. Regularly scheduled days off: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S	<b>DEPT USE:</b> Emp Ins Occ Nat Part Ev Src 2src
5. Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	6. Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	7. Shift on day of injury: (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) <input type="checkbox"/> Left <input type="checkbox"/> Right			9. Check here if you have more than one job: <input type="checkbox"/>	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				

**Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.**

11. Your legal name:	12. Worker's language preference other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):	13. Birthdate:	14. Gender: <input type="checkbox"/> M <input type="checkbox"/> F
15. Your mailing: Address _____ City _____ State _____ Zip _____		16. Home phone: _____	
17. Social Security no. (see back*): _____		18. Occupation: _____	19. Work phone: _____
20. Names of witnesses: _____			
21. Name and phone number of health insurance company: _____		22. Name and address of health care provider who treated you for the injury or illness you are now reporting: _____	
23. Have you previously injured this body part? <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. Were you hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
26. <b>By my signature</b> , I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. <b>Notice:</b> Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.			
27. <b>Worker signature:</b> _____		28. Completed by (please print): _____	29. Date: _____

**Employer**

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name:		31. Phone:	32. FEIN:
33. If worker leasing company, list client business name:		34. Client FEIN:	
35. Address of principal place of business (not P.O. Box):		36. Insurance policy no.:	
37. Street address from which worker is/was supervised: _____ ZIP: _____		38. Nature of business in which worker is/was supervised: _____	
39. Address where event occurred: _____			
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		41. Class code:	
42. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No	44. OSHA 300 log case no:	
45. Date employer knew of claim:	46. Worker's weekly wage: \$ _____	47. Date worker hired:	48. If fatal, date of death
49. Return-to-work status: Not returned <input type="checkbox"/> Regular Date: _____ Modified Date: _____		50. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
51. <b>Employer signature:</b> _____		52. Name and title (please print): _____	53. Date: _____

# A guide for workers recently hurt on the job

The following information is provided by SAIF Corporation at the request of the Workers' Compensation Division

**saif**corporation

400 High St. SE, Salem, OR 97312

## How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims,"** available from your health care provider.

## 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.

## Are there limitations to my medical treatment?

- **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.**

## 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?

- SAIF Corporation or your employer should be able to answer your questions. Call SAIF Corporation at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

### **Ombudsman for Injured Workers:**

#### **An advocate for injured workers**

Toll-free: 800.927.1271

Email: [oiw.questions@state.or.us](mailto:oiw.questions@state.or.us)

#### **Workers' Compensation Compliance Section**

Toll-free: 800.452.0288

Email: [workcomp.questions@state.or.us](mailto:workcomp.questions@state.or.us)

### \* **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**

You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).