Insert insurer name, address, and phone number

EMPLOYER's report of occupational injury or disease/illness

NOTE: This form satisfies OSHA Form 301 record-keeping requirements. Complete only this page (Page 1) if the worker is not filing a claim. If the worker completes Page 2 and files a workers' compensation claim, attach a copy of this form and send both to your insurer within five days of notice or knowledge of a claim.

1.Worker's name, mailing address, and phone:	2. Date of birth:	3. Male ☐ Female ☐	4. SSN:
	5. Date of hire:	6. State of hire:	7. Payroll class code:
8. Employer's name:	9. Insurance policy no.:		10. Employer FEIN:
11. Immediate supervisor's phone no.: / 12. Personnel phone number:	13. Nature of employer's business:		
14. Department and street address where event occurred:	15. Name and address of medical office (if treated away from work site):		
16. Street address of worker's normal workplace, if different from #14:	17. Name of worker's doctor or other health-care professional:		
18. Employer's business address, if different from #14 or #16:			

19. Injury occurred: ☐ On employer's premises ☐ On client's premises (if leased/temp worker) ☐ Off premises ☐ At unknown location

20. Client's name, if employer is leasing co. or temporary agency:

21. Client phone: / 22. Client FEIN:

23. Was worker treated in an emergency room?	☐ Yes ☐ No
24. Was worker hospitalized overnight as inpatient?	☐ Yes ☐ No
25. Did injury occur during course of job?	☐ Unknown ☐ Yes ☐ No
26. Was injury caused by person other than injured worker?	☐ Yes ☐ No
27. Was injury caused by failure of machinery or product?	☐ Yes ☐ No
28. Were other workers injured?	☐ Yes ☐ No
29. Is worker an owner or corporate officer?	☐ Yes ☐ No
30. Is worker "premium exempt" (a Preferred Worker)?	☐ Yes ☐ No

(If "Yes," attach copy of eligibility card or "Notice of Premium Exemption.")

31. Scheduled days off:

☐ S	☐ S	☐ M	☐ T	☐ W	☐ T	☐ F

32. No. of days worked per week:

34. Hours per shift:

35. Date left work:

36. Time left work: ☐ a.m. ☐ p.m.

33. Wage & wage period: 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.

37. Return-to-work status:
☐ Not returned
☐ Regular - Date:
☐ Modified - Date:

If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No

***EMPLOYER:** Do not release data above this line except as required or allowed by U.S. or Oregon laws. Under OAR 437-001-0700(20)(e), data BELOW this line must be released to the worker's collective-bargaining-agreement representative upon request.*

38. Describe how the incident/injury occurred, including the worker's activity, tools, equipment, and materials involved. Describe the injury or illness, including part of body affected and object or substance involved. Example: "Climbing a ladder while carrying roofing materials. Ladder slipped on wet floor and worker fell twenty feet to concrete floor and broke his shoulder."

39. Worker's shift on day of injury	(from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	40. Date of injury or illness:	41. Time of injury or illness: ☐ a.m. ☐ p.m.
42. X _____ *Employer's signature* *Date*			43. If fatal, date of death:
44. Print name, title, and phone number of signer:			45. OSHA log case number:

Attention: Report fatalities or catastrophes to DCBS/OR-OSHA within eight hours of occurrence. Call toll-free in Oregon (800) 922-2689 or (503) 378-3272. Report accidents that result in overnight hospitalization with medical treatment to the DCBS/OR-OSHA local field office within 24 hours of employer notification. At night or on weekends, call Oregon Emergency Response, (800) 452-0311.

Insert insurer name, address, and phone

WORKER's report of occupational injury or disease/illness claim

1. Worker's language preference: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other (please specify):

2. Worker's legal name (first, m.i., last):	3. Date of birth:	4. Male ☐ Female ☐	5. Social Security number (See attached "Notice to Worker"):
6. Worker's street, mailing, and e-mail addresses:	7. Date of injury/illness:	8. Time of injury/illness:	9. Last date worked:
	10. Nature of injury/illness (strain, cut, bruise, etc.):		11. Education: Grade completed (0-20):
Home phone:	12. Body part(s) affected:		☐ Left ☐ Right
Work phone:			
13. Employer's name, street address, and phone no.:	14. Name of medical provider who first treated injury/illness: Phone:		
	15. Name of regular doctor: Phone:		
16. Occupation (job title):	17. Name, phone, and ID or group no. of personal health insurer:		

18. Describe the injury or illness fully (how and where it occurred):

Witnesses (if any):

19. Has body part been injured before? (If "Yes," explain.) ☐ Yes ☐ No

20. Check here if you have more than one employer: ☐ See attached ***Understanding workers' compensation claims*** under **"If I can't work, will I receive payments from the insurer for lost wages?"** to find out if you are eligible for additional benefits.

21. By my signature: I am giving NOTICE OF CLAIM for workers' compensation medical or disability benefits. I certify that the above information is true to the best of my knowledge and belief. I authorize medical providers and other custodians of the claim record to release medical records relevant to the injury or disease claimed on this 801 to the workers' compensation insurance company and the Oregon Department of Consumer and Business Services. Medical information relevant to the claim includes a history of the complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. This form does not authorize release of the following information:

- Participation in federally funded treatment programs for drug and alcohol abuse under Fed. Regulation 42, CFR (2).
- HIV-related information unless the claimed condition is HIV or AIDS or when such information is relevant to the claimed condition(s).

I authorize the use of my SSN as described in Paragraph 2 on the attached "Notice to Worker." (If you do not authorize the use of your SSN as described in Paragraph 2, check here ☐.)

Dept. use

Emp no

Ins no

Occ

Nature

Part

Event

Source

Assoc Object

Worker: Sign form and give it to your employer on the day you sign it. Your employer will give you a copy.

X _____

Worker's signature ***Today's date***

Employer: Provide information below, sign form, and give the worker a copy immediately. Send a copy to the insurer, along with Page 1 or other injury/illness report, within 5 days of Notice of Claim. Retain a copy for your records.

22. Employer's legal name:	25. Name, title, and phone number of signer:
23. Employer's FEIN:	
24. Date employer first knew of claim:	**X** _____ ***Signature of employer representative*** ***Today's date***