|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Insert self-insured employer and insurer name, address, phone number, and service company, if any.* | | | | | | | | | | **Reporte de Lesión o Enfermedad en el Trabajo**  **(Report of Job Injury or Illness)**  Reclamación de compensación para trabajadores  (Workers’ compensation claim) | | | | | | | | | | | | | |
| **Trabajador (Worker)**  Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte de esta forma que corresponde al trabajador y entregela a su empleador. **Si usted no quiere hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea dejada para su firma.** Su empleador le dará una copia. (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. ) | | | | | | | | | | | | | | | | | | | | | | | |
| Fecha de la lesión o enfermedad (Date of injury or illness): | | | Fecha que dejó el trabajo  (Date you left work): | | | | | | | | | Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury): | | | | a.m.  p.m. | | Días que regularmente no trabaja (Regularly scheduled days off)    M T W T F S S | | | | | **Dept Use:** |
| Emp |
| Ins |
| Hora en la que ocurrió la lesión o enfermedad (Time of injury or illness): | a.m.  p.m. | | Hora que dejó el trabajo (Time you  left work): | | | | | a.m.  p.m. | | | | Marque este casillero si usted tiene más de un trabajo. (Check here if you have more than one job): | | | | | |
|
| Occ |
| Nat |
| ¿Cuál es su lesión o enfermedad? ¿En qué parte del cuerpo? ¿En qué lado? (Ejemplo: torcedura del pie derecho) What is your illness or injury? What part of the body? Which side? (Example: sprained right foot)  Izquierdo (Left)  Derecho (Right) | | | | | | | | | | | | | | | | | | | | | | |
| Part |
| Ev |
| ¿Cuál fue la causa? ¿Qué estaba haciendo? Incluya vehículo, maquinaria o herramienta usada. (Ejemplo: caí diez pies mientras subía una escalera de extención cargando una caja de materiales que pesaba 40 libras) 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) | | | | | | | | | | | | | | | | | | | | | | |
| Src |
| 2src |
| ***Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.*** | | | | | | | | | | | | | | | | | | | | | | | |
| Su nombre legal (Your legal name): | | | | | Idioma de preferencia (Language preference): | | | | | | | | | | | | Fecha de nacimiento (Birthdate): | | | | Sexo (Gender):  M  F | | |
| Su dirección postal (Your mailing address): | | | | | | | | | | | | | | | | | Teléfono del domicilio  (Home phone): | | | | | | |
| Número de Seguro Social SSN (Vea la Forma 3283) (See Form 3283): | | | | | | Ocupación (Occupation): | | | | | | | | | | | Teléfono del trabajo (Work phone): | | | | | | |
| Nombres de testigos (Names of witnesses): | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre y número de teléfono de la compañía aseguradora de salud (Name and phone number of health insurance company): | | | | | | | | | | | | | | Nombre y dirección del proveedor médico que le trató de la lesión o enfermedad que usted está ahora reportando (Name and address of health care provider who treated you for the injury or illness you are now reporting): | | | | | | | | | |
| ¿Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) Si  No | | | | | | | | | | | | | |
| ¿Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) Si  No | | | | | | | | | | | | | |
| **Con mi firma,** estoy presentando una reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos y a otros custodios de los récords de mi reclamación para emitir los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y al Departamento para Consumidores y Negocios de Oregon. **Aviso:** Los expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPAA no es requerida (45 CFR 164.512(I)). Para emitir récords sobre el HIV/AIDS (SIDA), ciertos récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.  **Yo entiendo que tengo el derecho de ver un proveedor para el cuidado de salud de mi elección sujeto a ciertas restricciones bajo ORS 656.260 y ORS 656.325.**  (**By my signature,** I am making a claim for workers’ 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. **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 understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.** | | | | | | | | | | | | | | | | | | | | | | | |
|
|
|
|
| Firma del trabajador  (Worker signature): | | | | | | | | | Completada por (Completed by)  Por favor escriba (please print): | | | | | | | | | | | | | Fecha  (Date): | |
| 440-801S (1/17 tr 1/17/DCBS/WCD/WEB) | | | | | | | | |  | | | | | | | | | | | | |  | |
|
|
| **Empleador (Employer)**  Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form. | | | | | | | | | | | | | | | | | | | | | | | |
| Employer legal  business name: | | | | | | | | | | | | | Phone: | | | | | | FEIN: | | | | |
| If worker leasing company,  list client business name: | | | | | | | | | | | | | | | | | | | Client  FEIN: | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | |
| Were other workers injured? Yes  No | | | | | | | | | | | | | | | | OSHA 300 log case #: | | | | | | | |
| Date employer  knew of claim: | | Date worker  returned to work: | | | | | | | | | Worker’s  weekly wage: $ | | | | | Date worker  hired: | | | | If fatal, date  of death: | | | |
| By my signature, I acknowledge I am responsible for notifying my workers’ compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker’s choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.** | | | | | | | | | | | | | | | | | | | | | | | |
| Employer  signature: | | | | | | | Name and title  (please print): | | | | | | | | | | | | | Date: | | | |
| 440-801S (1/17 tr 1/17/DCBS/WCD/WEB) | | | | | **OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.** | | | | | | | | | | | | | | | | | **801S** | | |