Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Saif Corporation
400 High St SE
Salem, OR 97312

saif801@saif.com
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 it 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:**
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part
				Ev
				Src
				2src

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.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:			
Home phone:	Work phone:	Occupation:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

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 requires 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.

Worker signature:	Completed by (please print):	Date:

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: **George Fox University**	Phone: **503 554 2180**	FEIN: **930386839**
If worker leasing company, list client business name: **N/A**		Client FEIN:
Address of principal place of business (not P.O. Box): **414 N. Meridian St, Newberg, OR 97132**		Insurance policy no.: **770846**
Street address from which worker is/was supervised: **same** 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 no:	
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): **Aga Luptak, Employee Benefits**	Date:

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.

801