



citycounty insurance services
www.cisoregon.org

CIS Workers' Compensation Group
c/o Citycounty Insurance Services
PO Box 1469
Lake Oswego, OR 97035
Phone: 1-800-922-2684 Fax: 503-763-3901

Report of Job Injury or Illness

Worker's 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 supervisor.

Date of injury or illness:	Date you left work:	Time you began work on day of injury:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regularly scheduled days off: Varies	DEPT. USE:
Time of injury or illness:	Time you left work:	Check here if you have more than one job:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> <input type="checkbox"/> M T W T F S S	Emp
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
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)					Occ
					Nat
					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 <input type="checkbox"/> F <input type="checkbox"/>
Your mailing address:	Home phone:		
Social Security no.:	Occupation:	Work phone:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who first treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>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.</p>			
Worker signature:	Date:	Completed by (please print):	

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.

Employer legal business name and mailing address:	City of Albany, Oregon P.O. Box 490, Albany, OR 97321	Phone: 541-917-7500
Address of principal place of business (not P.O. Box):	Albany City Hall 333 Broadalbin Street SW, Albany, OR 97321	Did injury occur during course of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address from which worker is/was supervised:	ZIP:	Return-to-work status: <input type="checkbox"/> Not returned <input type="checkbox"/> Regular – Date: <input type="checkbox"/> Modified – Date:
Address where event occurred:		
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	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	If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date employer knew of claim:	Worker's wage: \$	Date worker hired:
Dept. Code:		If fatal, date of death:
Payroll Class:		
Employer signature:	Name and title of signer (please print): Laura Hyde, 541-917-7508 Executive Assistant to the City Manager	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.