Multnomah Education Service District

Injured Worker Packet

New Claims and Information to Injured Workers

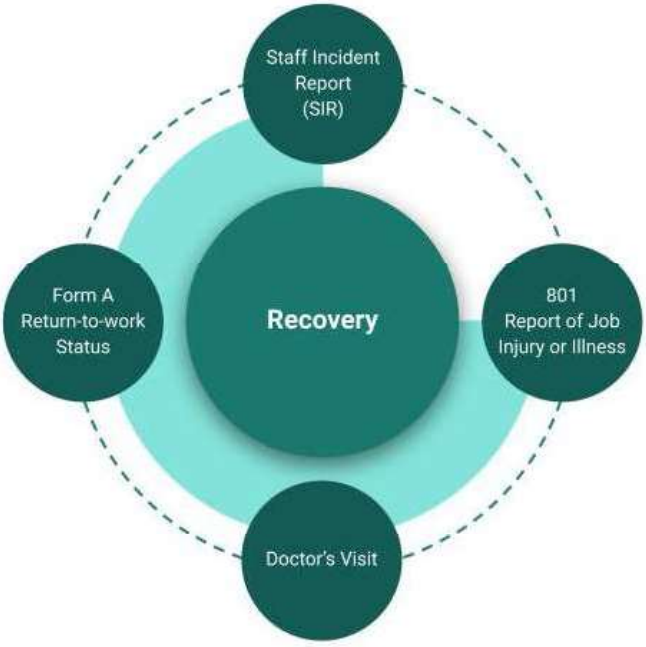
We are very sorry to learn about your injury.

We're here to help you get better quickly. This packet has important information about your new claim, including what you need to know and do. Please read it carefully. If you have any questions, reach out to your supervisor or the Human Resources Department.

11611 NE Ainsworth Circle • Portland, Oregon 97220 • (503) 255-1841 • MultnomahESD.org

Injury Packet Contents

- **List of occupational health clinics**
  You are **not** required to be treated by these doctors; this list is only provided as a courtesy to you.
- **Employee responsibilities**
  - Review this information and contact Human Resources at workplaceinjury@mesd.k12.or.us with any questions.
- **Forms for Medical Appointment**
  - 801 - Report of Job Injury or Illness
    - Complete this form and submit it to Human Resources at workplaceinjury@mesd.k12.or.us as soon as possible.
  - Return-to-Work Status Form
  - Modified Work Log
- **Important Contact Information**
- **Frequently Asked Questions**
- **A Guide for Workers Recently Hurt on the Job**
- **Notice to Worker**



Occupational Health and Urgent Care Clinic

This list is just for your convenience; you can choose any clinic, not just the ones on the list.

Concentra Medical Center
12518 NE Airport Way
Portland, OR 97230
503.256.2992

Adventist Health Occ. & Enviro Med
10201 SE Main St
Portland, OR 97216
503.251.6363

Adventist Health Urgent Care Parkrose
1350 NE 122nd Ave
Portland, OR 97230
503.408.7008

Adventist Health Urgent Care Sandy
17055 Ruben Ln
Sandy, OR 97055
503.668.8002

Kaiser Permanente Gateway
1700 NE 102nd Ave
Portland, OR 97220
971.229.6990

Kaiser Permanente Interstate
3600 N Interstate Ave
Portland, OR 97227
503.571.3366

Kaiser Permanente Mt. Talbert
10100 SE Sunnyside Rd
Clackamas, OR 97015
503.571.3366

Kaiser Permanente Rockwood
19500 SE Stark St
Portland, OR 97233
503.571.3366

Legacy-GoHealth Urgent Care
22262 NE Glisan St
Gresham, OR 97030
503.489.2024

Legacy-GoHealth Urgent Care
2850 SE Powell Valley Rd
UNIT 100
Gresham, OR 97080
503.666.5050

Legacy-GoHealth Urgent Care Sunnyside
10151 SE Sunnyside Rd
Clackamas, OR 97015
503.414.5700

Providence Immediate Care Gateway
1321 NE 99th Ave
Portland, OR 97220
503.215.9900

Providence Occ. Health
9290 SW Sunnyside Blvd
Clackamas, OR 97015

Zoom+care
zoomcare.com
Locations throughout the Portland area

We do our best to update this list as we find out about any changes but cannot guarantee accuracy. We recommend you visit the clinic's website or call ahead to confirm hours/location, etc. If you note any errors, please inform your return-to-work consultant so the list can be updated. Thank you.

Employee Responsibilities

1. Fill out the Staff Incident Report (SIR) as soon as possible. If you need medical care, also fill out the 801 form right away.

2. It's your job to make sure the doctor fills out any return-to-work forms and to keep us updated about your progress and work limits. **If you can't return to work yet, you must call your supervisor and Human Resources every week with an update.**

3. If you are cleared to go back to work, **return to your job with your doctor's release form within 24 hours of your appointment.** Please remember, SAIF doesn't cover lost wages for attending medical appointments, so it's best to schedule them before or after your work hours.

4. Follow your doctor's instructions. **You need to take a Return-to-Work Status form to your doctor at your first visit and any follow-up visits.** Turn in this form to Human Resources within 24 hours of your appointment. If you need more return-to-work forms, contact Human Resources.

5. SAIF will assign an adjuster and send you their contact details, usually by US mail. Answer any calls from your SAIF adjuster quickly so your claim can be handled properly. If you have questions, ask your adjuster and keep their information handy in this packet.

6. MESD will follow your doctor's written instructions about work restrictions. If you have any questions, reach out to your supervisor or Human Resources. You can also ask your SAIF adjuster. We all share the same goal: helping you recover fully and get back to your regular activities, both at work and at home.

7. If you return to work with any restrictions, you'll need to fill out a Modified Work Log every day and give it to your supervisor at the end of each week.

saif

400 High St. SE
Salem, OR 97312

For SAIF Customer Use
Area _____ _____ _____
Dept. _____
Shift _____ CC _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

Email: 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

To make a claim for a work-related injury or illness, fill out this form and give to your employer.

If you do not intend to file a workers' compensation claim with SAIF, 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: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S	**DEPT USE:**
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.		Emp
				Ins
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right			9. Check here if you have more than one job: ☐	Occ
				Nat
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)				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.

11. Your legal name:	12. Language preference:	13. Birthdate: / /	14. Gender: ☐ M ☐ F
15. Your mailing address: City: State: ZIP:			16. Mobile/home phone:
17. Occupation:			18. Work phone:
19. Names of witnesses:		20. Your email address (Optional):	
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? ☐ Yes ☐ No			
24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
25. Were you treated in the emergency room? ☐ Yes ☐ No			

26. By my signature, 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. **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.**

27. Worker signature:	28. Completed by (please print):	29. Date: / /

Employer at time of injury

Complete the rest of this form and give a copy of the form to the worker. If the worker is unavailable, complete with available information. Notify SAIF 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: Multnomah Education Service District		31. Phone: (503) 255-1841	32. FEIN: 936000829
33. If worker leasing company, list client business name:			34. Client FEIN:
35. Address of principal place of business (not P.O. Box): 11611 NE Ainsworth Circle Portland, OR 97220			36. Insurance policy no.:
37. Street address from which worker is/was supervised: 11611 NE Ainsworth Circle Portland, OR 97220		ZIP: 97220	38. Nature of business in which worker is/was supervised: Education
39. Address where event occurred: 11611 NE Ainsworth Circle Portland, OR 97220			
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No			41. Class code: 9349
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ 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 ☐ Regular Date: / / ☐ Modified Date: / /			If modified work, is it regular hours and wages? ☐ Yes ☐ No

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.**

50. Employer signature	51. Name and title (please print):	52. Date: / /

801
Form 801 12.20

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.

**This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division.*

Return form to:

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

WORK STATUS *(Select one option)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 – Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____

Return form to:

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

WORK STATUS *(Select one option)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 – Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____

Return form to:

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

WORK STATUS *(Select one option)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 – Released to Modified Work** Status from (date): _____ to: _____

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____

Modified Work Log

As an injured worker, a modified work log is a helpful tool for both you and your employer. Here's how:

Benefits to You:

- **Accurate Time-Loss Payments:** By tracking your hours worked and missed, you can help ensure you receive the correct amount of time-loss benefits.
- **Clear Communication with Your Employer:** The log provides a clear record of your work activities and any limitations, reducing potential misunderstandings.
- **Support for Your Claims:** Your signed log can help verify your compliance with work restrictions and support your claim for benefits.

Benefits to Your Employer:

- **Efficient Claims Management:** The log helps your employer track your progress and communicate effectively with the insurance adjuster.
- **Compliance with Work Restrictions:** By reviewing the log, yor employer can ensure that you are not exceeding your limitations.
- **Potential for Faster Recovery:** Modified work can help you stay engaged and productive, potentially speeding up your recovery process.

By using a modified work log, we can work together to manage your return to work and ensure a smooth claims process.

Please complete all sections for every day you are on modified work. If you need help completing it, your supervisor or HR can help. At the end of each week, sign it and have your supervisor sign it. Your supervisor should get the original and you can keep a copy for your records.

Modified Work Log

Worker Name: ______________________ **Claim No.:** __________________________

Describe your current work restrictions: ____
____

Date	Modified Work Performed	Within Restrictions?
	List specific duties: Hours Worked ____ *If you missed any time from work today, please note the reason:*	☐ Yes ☐ No*
	List specific duties: Hours Worked ____ *If you missed any time from work today, please note the reason:*	☐ Yes ☐ No*
	List specific duties: Hours Worked ____ *If you missed any time from work today, please note the reason:*	☐ Yes ☐ No*
	List specific duties: Hours Worked ____ *If you missed any time from work today, please note the reason:*	☐ Yes ☐ No*
	List specific duties: Hours Worked ____ *If you missed any time from work today, please note the reason:*	☐ Yes ☐ No*

Worker Signature: ____________________________ Date: _____________

Supervisor Signature: ___________________________ Date: _____________

*If you feel the work you are performing is **not** within the restrictions provided by your attending physician, **immediately** contact your supervisor or the Human Resources Department to discuss this.

Important Contact Information

Employer Representative:

Title: Leave Specialist

Phone no.: 503-257-1570

Fax. no.: 503-257-1620

Email: workplaceinjury@mesd.k12.or.us

Workers' Compensation Insurance Company

SAIF
400 High St SE
Salem, OR 97312-9901
Phone: 800.285.8525
http://www.saif.com/

Our policy number: 487589

Your Saif claim number*:_____

Adjuster name*:_____ Extension: _____

You can also visit https://saif.com/worker.html to review important information about your claim, including the claim process, medical and prescription help, payments for bills and time loss, and much more. You can also sign up for *MyClaim* to see your claim data, payment history, access claim forms, and more.

*This information will be provided by SAIF after your claim has been accepted.
Keep this page for future reference.

Frequently Asked Questions (FAQs)

I got hurt at work, but I didn't go to the doctor. What should I do?
If you get hurt at work, you must fill out a Staff Incident Report (SIR). You can find this form on the staff portal of the MESD website. If you need help finding or filling out the SIR, the administrative assistant can assist you.

How do I know if I need to file a workers' compensation claim?
Not all injuries at work result in a workers' compensation (WC) claim. If you only need basic first aid, it doesn't count as a WC claim, and no extra steps are needed. However, if you need to see a licensed medical provider for treatment, a WC claim should be started. You can choose whether or not you want to file a claim.

How do I start a workers' compensation claim?
If you visit a medical provider for your injury, you need to complete an 801 form. When you tell the doctor you were hurt at work, they will fill out an 827 form and send it to SAIF, our workers' compensation (WC) insurer, which starts a claim. Even when the doctor submits an 827 form, you are still responsible for completing the 801 form and sending it to the Leave Specialist in HR. HR will then send the 801 form to SAIF for you.

What is "time loss" and how do I get paid if I can't work?
One element of WC is "time loss". If an employee is injured and cannot work due to their doctor's orders, SAIF may pay the employee for a portion of the time they are unable to work.

Workers' compensation (WC) claims for time loss start after the injured employee has missed 14 days of work. However, the first 3 days, called the "waiting period," are not covered by SAIF. You can use your accrued leave during this time.

Once your claim is accepted, SAIF will only pay about 2/3 of your gross wages (your earnings before taxes). You can use your accrued leave to cover the remaining 1/3 of your scheduled work hours. If you want to use your leave to make up the difference, contact the Leave Specialist for help.

Do I have to talk to the claims adjuster?
SAIF assigns a claims adjuster to handle your claim. It's just as important to communicate with your claims adjuster as it is to keep your supervisor informed, even if you're on time loss. The adjuster needs updates on your condition. If you don't respond, your benefits might be paused until you get back in touch with them.

What does it mean if my doctor says I can go back to work on light duty?
If your doctor approves you for modified work, send a copy of the Return to Work Status form (also called a "work release") to both your adjuster and your supervisor as soon as possible. Make sure to give a copy to your employer and the adjuster, and keep one for your own records.

If you can't do your regular job because of your medical restrictions, HR and your supervisor will work together to find modified work for you. This could be a different job entirely or a version of your regular job with adjustments to fit your needs.

A guide for workers recently hurt on the job

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

saif
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, "Workers' and Health Care Provider's Report for Workers' Compensation Claim,"** 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
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic physicians
  - Physician assistants
  - Podiatric physicians
  - 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 or your employer should be able to answer your questions. Call SAIF 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@oregon.gov

Workers' Compensation Resolution Section

Toll-free: 800.452.0288

Email: workcomp.questions@oregon.gov

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, 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 the following: 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).

Form 3283* | SAIF 12.20 (440-3283, 01/21/DCBS/WCD/WEB) for distribution with Form 801.
**This form was modified by SAIF Corporation, and has been approved for use by the Oregon Workers' Compensation Division.*

Notice to Worker

Oregon law requires your employer's insurer to provide this information. [Oregon Revised Statute (ORS) 656.262(6)]

The notice of acceptance must tell you what medical conditions are accepted and whether your claim is disabling or nondisabling.

Nondisabling claims – reclassification review
Generally, if your claim has been classified as nondisabling, that means the insurer concluded no disability payments are due and all of the following are true:

- You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.
- You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.
- It appears you will not have any permanent disability as a result of your injury.

If you think the insurer made a mistake in classifying your claim as nondisabling, you have the right to object to that decision by requesting reclassification under ORS 656.277. You need to contact the insurer and request reclassification within one year of the date the insurer accepted your claim. The insurer must complete its review and send you its decision within 14 days of receiving your request. If the insurer's decision is that your claim is correctly classified as nondisabling and you still disagree, you have the right to request – within 60 days of the date of the insurer's notice – that the Workers' Compensation Division review your claim to determine if the nondisabling classification is correct. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the division to review the classification of your claim.

Nondisabling claims – aggravation (worsening) of injury-caused conditions
If your claim is nondisabling, you may be entitled to benefits for an aggravation if your injury-related condition worsens. Ask your doctor for Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," and check the box "Report of aggravation of original injury." Complete and sign your section of the form and give it to your doctor. Your doctor will complete the remainder of the form and send it to the insurer. If your injury remains nondisabling for at least one year after the date your claim was accepted, your aggravation rights will expire five years after the date of your injury.

After your aggravation rights expire, you are entitled to limited benefits.

Employment reinstatement rights and responsibilities under ORS chapter 659A
In most cases, ORS 659A.043 requires an employer with more than 20 employees to reinstate a permanent worker when the worker's attending physician or authorized nurse practitioner has approved the worker's return to regular work or other suitable work. For purposes of reinstatement rights, your attending physician is the doctor or physician assistant who is primarily responsible for the treatment of your injury, as described in ORS 656.005(12). If your employer at the time of your injury (employer at injury) is required to reinstate workers, your employer at injury must return you to the job you were doing at the time of your injury upon your request to be reinstated, unless that job no longer exists, that job is unavailable, or your work-related disabilities prevent you from doing your former duties. A job is "available" even if filled by a replacement worker during your absence. If your job is not available, your employer must return you to any other existing position that is vacant and suitable.

A certificate from your attending physician or authorized nurse practitioner stating that you can return to your regular job or other suitable job is enough evidence that you are able to do the job. However, your reinstatement rights may be limited by seniority rights and other employment restrictions contained in a valid collective bargaining agreement between your employer and an employee representative.

Within five days after your attending physician or authorized nurse practitioner notifies the insurer that you are released to return to work, the insurer must inform you about the opportunity to request work with your employer-at-injury.

You will lose your right to be reinstated to your regular job if any of the following are true:

- Your attending physician, or a medical arbiter determines that you are medically stationary, but not physically able to return to your regular job.
- You are eligible for and participate in vocational assistance under ORS 656.340.
- You accept a suitable job with another employer after becoming medically stationary.
- You refuse a bona fide offer from your employer of suitable light duty or modified employment before you become medically stationary.
- You did not request reinstatement within seven days of receiving certified mail from the insurer notifying you that your attending physician or authorized nurse practitioner approved you to return to your regular work or other suitable work.
- Three years have passed since your date of injury.
- You are fired for valid reasons not connected with the injury and for which others are or would be discharged.
- You clearly abandoned employment with the employer.

Reinstatement rights do not apply if any of the following are true:

- You were hired on a temporary basis as a replacement for an injured worker.
- You are a seasonal worker employed to perform less than six months' work in a calendar year.
- Your job at injury resulted from a referral to short-term employment from a hiring hall operating under a collective bargaining agreement.
- Your employer has 20 or fewer workers at the time of your injury **and** at the time of your demand for reinstatement.

If you have questions or complaints related to your reinstatement rights, contact the Oregon Bureau of Labor and Industries (BOLI). Contact information for BOLI is located at the end of this notice.

Re-employment assistance under ORS 656.622

The division has a re-employment assistance program: **The Employer-at-Injury Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through this program while your claim is open. Your employer may contact [insurer name and phone number].**

Reimbursement for your injury-related expenses, OAR 436-009-0025

The insurer will reimburse you for claim-related expenses, such as prescriptions, transportation, meals, and lodging necessary to attend medical appointments, with some limitations and up to a maximum amount. You must request reimbursement in writing and include copies of receipts or other supporting

documentation as required by the insurer. The insurer must receive your request for reimbursement within two years of the date you paid for the expense or within two years of the date your claim is determined compensable, whichever is later. Form 3921 "Request for Reimbursement of Expenses" is available at wcd.oregon.gov or the insurer may provide a form for requesting reimbursement.

Omitted medical conditions or incorrect notices of acceptance
If you think a medical condition was not included in the notice of acceptance, or the notice is incomplete or incorrect, you must notify the insurer in writing. Explain why you think the notice of acceptance is wrong. You may notify the insurer using Form 827 – see under "New medical condition" below.

New medical condition
If you develop a new medical condition that you believe should be accepted under your claim after your claim has been accepted, you must write to the insurer, identify the condition as being a "new medical condition," and request formal written acceptance of the condition. You may notify the insurer using Form 827 – see below.

- Requesting new or omitted medical conditions using Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claim": Ask your health care provider for Form 827, complete your section of the form, check the box "Request for acceptance of a new or omitted medical condition on an existing claim," indicate what condition you believe should be accepted, sign the form, and return the form to your doctor so it can be forwarded to the insurer.

Expedited claim service, ORS 656.291
If you disagree with actions taken in your claim, and your claim qualifies, you may be entitled to an expedited hearing by the Hearings Division of the Workers' Compensation Board within 30 days of your request for hearing if any of the following is true:

- The dispute does not involve the compensability of or responsibility for your claim, and the total amount in dispute (not including any penalties and attorney fees) is $1,000 or less.
- The only issue in the dispute is the entitlement to penalties or related attorney fees.
- The dispute arose because your claim was denied under ORS 656.262(15) due to the insurer's belief that you did not cooperate with its investigation.

If you have questions about your claim, contact your employer or insurer. If you have additional questions, contact one or more of the following:

Oregon Department of Consumer and Business Services

Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
503-947-7585, or toll-free, 800-452-0288

Ombuds Office for Oregon Workers, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
503-378-3351, or toll-free, 800-927-1271

Oregon Bureau of Labor & Industries

Phone: 971-673-0761, email: BOLI_help@boli.oregon.gov, website: oregon.gov/boli