OFFICE MANAGER:

- **Contact the Safety-Risk & Loss Control Specialist at the District Office via email or phone immediately if a medical incident has occurred.**

  541-967-4505, option 3
  risk@albany.k12.or.us

- **Give Packet to Person Needing Workers Comp Forms.**

If you have any questions, please contact the Safety-Risk & Loss Control Specialist at the District Office. 541-967-4505, option 3

TO	FROM
District Office: Safety/Risk	

EMPLOYEE:
Please fill out the Employee Incident Report and the 801, then send to the Safety-Risk & Loss Control Specialist at the District Office ASAP.

IF NO MEDICAL TREATMENT

Injured Employee Responsibility:

- Initial when forms are completed.

Done	Completed By	Returned to	Action
	Employee	Office Mgr	Fill out and sign Employee Incident Report Form

Office Manager Responsibility

Done	Completed By	Returned to	Action
	Office Mgr	Safety-Risk & Loss Control Specialist	Send Employee Incident Report Form to Risk Management via inter office mail.

IF MEDICAL TREATMENT SOUGHT

Injured Employee Responsibility:

- Communicate with Office Manager and Supervisor about the situation
- Initial when forms are completed.
- Send the Workers Compensation paperwork to the Safety-Risk & Loss Control Specialist at the Business Office immediately.

Done	Completed By	Returned to	Action
	Employee	Office Mgr	Fill out 801 Form
	Employee	Office Mgr	Fill out Employee Incident Report Form
	Employee	Office Mgr	Copies of the Work Release from the Dr. Office
	Employee	Physician	Physician Memo: Release to Return to Work
	Employee	Keep	Guide for workers recently hurt, and Understanding Workers Compensation Claims

Office Manager Responsibility:

- Immediately notify Safety-Risk & Loss Control Specialist at the District Office and Supervising Administrator of Employee that an accident occurred, and employee is going to the Doctor.
- If Employee doesn't have access to a copy machine, please copy paperwork for Employee.

Done	Completed By	Returned to	Action
	Office Mgr	Safety-Risk & Loss Control Specialist	Send Employee Incident Report Form, 801 form and all accompanying Dr. release paperwork to the District Office via inter office mail, ASAP.

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

Employee Fill Out Top Section

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
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: ☐	Ins
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)				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.

11. Your legal name:	12. Language preference:	13. Birthdate:	14. Gender: ☐ M ☐ F Other:
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:

District Office Fill Out this Section 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: **Greater Albany Public School District**	31. Phone: **(541)967-4505**	32. FEIN: **936002755**
33. If worker leasing company, list client business name: ----------		34. Client FEIN: ----------
35. Address of principal place of business (not P.O. Box): **718 7th Ave. SW, Albany OR 97321**		36. Insurance policy no.: **771300**
37. Street address from which worker is/was supervised: ZIP:		38. Nature of business in which worker is/was supervised: **School**
39. Address where event occurred:		
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:
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): Julie Mayfield - Safety/Risk And Loss Control	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.*

Rev: 9/19/2025

Greater Albany Public Schools 8J
Employee Incident Report

This form is not a workers comp form, this is for incidents not requiring medical treatment. If incident requiries medical treatment please fill out a Worker's Comp Packet.

Name (Print): _____ Employee Position: _____

Date of Incident: _____ Time of Incident: _____ am / pm

School / Building: _____ Normal Shift: _____ am / pm _____ am / pm

Names and Contact Information of Witness(s):

Where Incident Happened:

Description of Incident:

Cause of Incident:

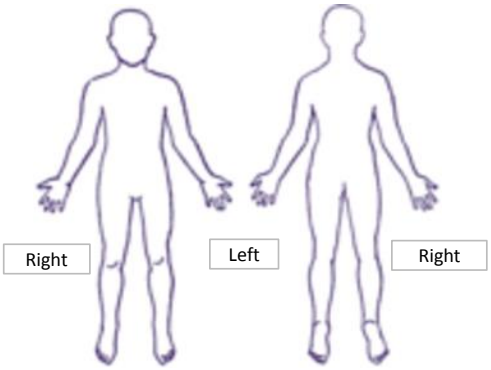
Was First Aid Used? ☐ Yes ☐ No What was done? (applied a band aide, ice pack etc.)

Body Part Affected:

Student Initials (if student caused injury) Please use first 2 letters of first name and first 2 letters of last name _____

Please show on below scale body part affected and the level of pain.

M: Mild Pain
A: Achy Pain
S: Severe Pain



Employee Signature: _____ Date: _____

Supervisor/Administrator Signature: _____ Date: _____

Office Manager - Incident # _____

Revised 12/11/2025

For Medical Provider to fill out if needed

Return form to: **Greater Albany Public School District Office, 718 SW 7th Ave., Albany, OR 97321**

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.: _____

440-3245 (2/16/DCBS/WCD/WEB)

Revised 9/19/2025

Employee Keep for Personal Files

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, "Worker's and Physician's Report for Workers' Compensation Claims,"** 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
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - 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 Compliance 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, and don't provide it, 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: 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).

440-3283 (01/17/DCBS/WCD/WEB) for distribution with X801 SAIF 1/17

Employee keep for personal files

saifcorporation
400 High Street, S.E., Salem, OR 97312-1801

keep this for your records

Understanding workers' compensation claims
A guide for workers recently hurt on the job

With some exceptions you must file a workers' compensation claim with your employer within 90 days of injury or within one year of learning you have an occupational injury or illness. Failure to do so may result in denial of the claim. Knowingly making a false statement or representation for the purpose of obtaining a benefit or payment is punishable by law.

Form 801 is your receipt that you gave notice of a claim. Keep a copy as your record. Your employer is required to submit your claim to its insurer within five days. The insurer must notify you of its acceptance or denial of your claim within 60 days after the date your employer knows of your claim. If your employer is self-insured, the acceptance or denial notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. If your claim is denied, the reason for the denial and your rights will be explained.

If you have questions, contact your employer's workers' compensation insurer. If you do not know who your insurer is, call the Employer Index in Salem at (503) 947-7814 or toll-free (888) 877-5670.

If you have a disabling claim, your insurer will send you a brochure called *"What happens if I'm hurt on the job?"* that should answer many of your questions. If you still have questions, call the Ombudsman for Injured Workers for help understanding your rights and responsibilities: (503) 378-3351, (800) 927-1271, or TTY (503) 947-7189. For general information about benefits, call the Workers' Compensation Division at (503) 947-7585, (800) 452-0288, or TTY (503) 947-7993.

Tell your doctor or authorized nurse practitioner that you were hurt on the job.
Your doctor or authorized nurse practitioner will ask you to fill out a Form 827 – *"Worker's and Physician's Report for Workers' Compensation Claims."* Your doctor or authorized nurse practitioner will send the Form 827 to the insurer for you.

May I get treatment from any doctor?
Unless the insurer has enrolled you in a managed-care organization (MCO), you may treat with any medical provider who qualifies as an "attending physician" under Oregon law or any authorized nurse practitioner. Your attending physician or authorized nurse practitioner is primarily responsible for your care and will tell you if there are any limits to the services he or she can provide.

Only your attending physician or authorized nurse practitioner can authorize time off work, reduce your work hours or duties, or release you to go back to work.

Who will pay my medical bills?
If your claim is accepted, the insurer will pay medical bills related to the medical condition they accepted in writing. **Save your receipts** for prescription medications, transportation, and other bills you pay for treatment related to the medical condition the insurer accepted. You may then request reimbursement in writing from the insurer.

Bills are not paid if your claim is denied or if the bills are related to a condition other than that accepted in writing by the insurer. Contact the insurer if you have questions.

If I can't work, will I receive payments for lost wages?
You will receive temporary disability payments if your attending physician or authorized nurse practitioner notifies the insurer that you **cannot work** due to your injuries or releases you to modified work that results in a loss of wages. Generally, you will not be paid for the first three calendar days of lost wages. However, you may receive payment for those three days if you are not released to do any type of work for at least 14 days from the time you left work, or if you were admitted to a hospital during your first 14 days of total disability.

If you have another job, you may be eligible to receive supplemental disability payments. To receive these benefits, you must notify the insurer about your other job(s) **within 30 days of the insurer's receipt of your initial claim** and provide proof of wages paid to you on the other job(s) (i.e., check stubs or payroll records).

What can I do to make sure I receive benefits to which I am entitled?

- **Find out the legal business name of your employer** and the name of its workers' compensation insurer. The Employer Index can help you identify the insurer if the employer is known.
- **Keep all medical appointments** and follow your attending physician's or authorized nurse practitioner's instructions.
- **Read and keep copies** of all letters and forms you receive regarding your claim.
- **Keep notes** of phone calls, including with whom you speak, subject matter, and dates.
- **Observe all deadlines.** Do not be late to submit information or to file appeals.
- **Contact your employer** immediately when your doctor releases you for work.
- **If you have questions** about your claim that are not resolved by your employer or insurer, contact the Ombudsman for Injured Workers at (800) 927-1271.

Greater Albany Public School District

718 7th Ave SW, Albany OR 97321
Phone: 541-967-4505
Fax: 541-967-4587

Memo

To: Whom It May Concern

From: Safety-Risk & Loss Control Specialist – District Office

Date:

Re: Worker's Comp Carrier

For Attending Dr. Office: (Urgent Care, Occupational Medicine, Emergency Room, etc.)

Billing Information for GAPS worker's compensation carrier

Greater Albany Public School has and initiates an Employee Return to work program.

Policy #: 771300

SAIF

400 High Street SE

Salem OR 97312

Phone: 1-800-285-8525

Revised 9/19/2025