DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Injured Worker Responsibilities & Information

For work-related injuries, illnesses or incidents

SOCP Safety Prog:
503-378-5952 ext 232
FAX: 503-378-5917

PLEASE READ CAREFULLY.

Employee incident/injury forms are available from your Supervisor and SOCP SafetyNet page on-line.

1: Report all incidents/injuries to your supervisor as soon as possible, but ***always before leaving*** the premises.

2: Fill out, sign, and review all employee injury reports before you go to the doctor, unless prevented from doing so due to the need for emergency medical treatment.

A. Complete "Employee Incident/Accident Report" (SOCP 001). This report documents the incident should you need to seek medical treatment at the time of the incident or at a later time.

B. If you seek MEDICAL ATTENTION, you must:

1. Complete "Form 801" before leaving the work site, give it to and review with your supervisor.
2. Provide a "Physical Assessment Form" (doctor's slip) to your supervisor within 24 hours after each medical appointment. Follow-up medical slips should be submitted to your supervisor after each visit or *at least* every 2 weeks.
3. Read and sign the "Modified Work Assignment letter" before starting modified work.
4. If on a modified assignment, give your supervisor new medical documentation within 24 hours after each doctor's visit or *at least* every 2 weeks.
5. Time loss, as defined by Workers' Comp, ***must*** be authorized by a doctor.
6. If you are on time loss, complete the "SOCP Worker's Compensation Associated Leave Choice" form and submit to your supervisor.
7. If your claim is denied, contact your supervisor about other options you may have.

3: IF YOU ARE UNABLE to complete the required paper work prior to receiving emergency medical treatment, you must notify your Supervisor (or Designee) no later than 24 hours after receiving emergency treatment. If you cannot complete the forms in person within 24 hours, the following information must be called in to your supervisor.

A. The time, location and date of injury.
B. A brief description of your injury.
C. Names of witnesses/others involved (when applicable).
D. Your return to work status.
E. Name, address and phone number of the treating physician.

You *MUST* report in person to complete all forms as soon as you are physically able.

4: You ***MUST*** keep SOCP informed at all times about your medical condition and your return to work status. You must also inform your physician that SOCP offers modified work for injured workers. Give your physician a "Physical Assessment" form to fill out and return to your supervisor.

A. If you are released for regular or modified work: Immediately take the written release to your supervisor and report to work as directed.

B. If you are *NOT* release for regular or modified work: Provide your supervisor with a "Physical Assessment" form (doctor's slip) within 24 hours after each doctor's visit (follow-up slips are required at least every 2 weeks), which should include a written statement indicating your inability to work due to the injury and the anticipated duration. Remember, Time Loss (as defined by Worker's Comp) must be authorized by your doctor.

Continued on back >>

5:	IF medical visits for follow-up treatment are scheduled during your regular working hours, pre-arrangements must be made with your supervisor.

6:	KEEP your Supervisor and Personnel (Human Resources) informed at all times of your current address and phone number (even if unlisted).

FAILURE TO COMPLY with the responsibilities outlined above may result in disciplinary action and may affect benefits under Worker's Compensation Laws related to the injury.

If you have questions, contact your Supervisor or the SOCP Safety Office at (503) 378-5952 ext. 232.

All Safety forms are located on the SOCP SafetyNet Page:

- SOCP 001 Employee Incident/Accident Report
- SOCP 003 Modified Work Assignment
- SOCP 005 Physical Assessment Form
- Worker's Compensation Associated Leave Choice (for AFSCME and ONA Employees)
- Interoffice memorandum – In & Out-of-House Postings
- SAIF 801 Form

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

For SAIF Customer U
Area
Dept.

Clear Form

D.
DATE
CLASS
DEFAULT DATE
MPLOYER'S
CCOUNT NO.

Toll Free Phone: 1-800-285-8525
Toll Free FAX: 1-800-475-7785

Report of Job Injury or Illness

Workers' compensation claim

This form can be filled in on the computer (see note in yellow bubble above), but cannot saved.

Worker

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 SAIF Corporation, 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. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Check here if you are employed by more than one employer: ☐	

8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right	9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):
10. 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)	
11. Name of witnesses:	12. Have you previously injured this body part? ☐ Yes ☐ No
13. Your legal name:	14. Birthdate: / 15. Gender: ☐ M ☐ F
16. Mailing address, city, state and zip:	17. Home phone:
18. SSN (See #25 below): / 19. Occupation:	20. Work phone:
21. Name of physician or health-care professional:	22. If medical treatment was given away from the worksite, print name and address of facility:
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No	
24. Were you treated in the emergency room? ☐ Yes ☐ No	

25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers 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 authorize the use of my SSN in the processing of this claim. (Authorizing the use of your SSN will ensure prompt processing of your claim and that your medical records are not released to unauthorized parties. If you do not authorize the use of your SSN, check here ☐.)

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

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation 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.

29. Employer legal business name: SOCP EMP #5849294 __ __ __	30. Phone: (503) 378-5952 ext. 232	31. FEIN: 93-0710952
32. If worker leasing company, list client business name: N/A		33. Client FEIN: N/A
34. Address of principal place of business (not P.O. box): 4494 River Road N, Keizer, OR 97303		35. Insurance policy no.: 312146
36. Street address from which worker is/was supervised: ZIP:		37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred:		
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		40. Class code: 9499
41. Were other workers injured? ☐ Yes ☐ No	42. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No	43. OSHA 300 log case #:

44. Date employer knew of claim:	45. Worker's monthly wage: $	46. Date worker hired:	47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:			49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature:	51. Name, title, and phone (please print):		52. Date:

801
X801 1/05

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

801

Print form

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

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.

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Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
FAX: 503-378-5915

Name: _____ Employee ID #: _____

Address: _____ _____ **Home phone:** _____
(city, state, zip code)

Regularly assigned shift hours: _____ Days off: _____

Accident information:

Date of incident: _____ Time of incident: _____ Exact location of incident: _____

Time shift began: _____ Was a Client involved? Yes ☐ No☐ Client initials: _____

Witness(es): *Do not list clients as witnesses.*

_____ _____

_____ _____

Body part injured (R/L): _____ Nature of the injury: _____

Describe the incident fully:

What caused the incident?

How could the incident have been prevented:

Employee signature: _____ Date: _____

SUPERVISOR SECTION: (see back for identifying factors which contributed to or caused the accident).

Analysis of the incident

Why it happened – Hazardous condition ☐ Unsafe behavior ☐ System weakness ☐ Other ☐

Explain: _____

Action taken to prevent a similar incident:

Client involved? Yes ☐ No☐ Entered into THERAP? Yes ☐ No☐

Employee - Went back to work: Yes ☐ No ☐ | Went home: Yes ☐ No ☐ | Went to Doctor*: Yes ☐ No ☐

_____ _____
Supervisor signature ***Date***

*NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.)

OVER >

SOCP Employee Incident/Accident Analysis

System challenges:

Management - Do we have:
Policy enforcement
Hazard recognition
Accountability
Supervisor training
Corrective action
Production priority
Proper resources
Job safety training
Hiring practices
Maintenance
Adequate staffing

Employee - Was the employee:
Following procedure
Training
Previous injury
Mental ability
Physical capacity
Equipment use
Short cuts
PPE Worn
Safety attitude

Equipment - Do we have:
Proper tool selection
Tool availability
Maintenance
Visual warnings
Guarding

Environmental - What about:

Plant layout	Vibration
Chemical	Lighting
Temperature	Ventilation
Noise	Housekeeping
Radiation	Biological
Weather	Ergonomics
Terrain	

Additional casual factors:
- ☐ Faulty equipment
- ☐ Non-employee
- ☐ Prior injury
- ☐ Late reporting
- ☐ Off-the-Job injury

Explain any checked boxes >>>>

Employee name: _____

Identify factors which contributed to or caused accident
(refer to list on left side of page):

Management:	Employee:
Equipment:	Environment:

Counter measures/best practices to prevent reoccurrence:

Who:	**By when:**

Explain any checked boxes for "Additional casual factors":

Safety Program Phone: 503-378-5952 ext 232
Safety Program FAX: 503-378-5915

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Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Physical Assessment form

005

SOCP Safety Program:
503-378-5952 ext 232 /FAX:503-378-5917

State Operated Community Program is interested in returning our injured staff back to work as safely as possible. One aspect of our injury program is returning an injured employee to modified work as soon as possible after the date of injury. Please provide the following information so we can best determine suitable job placement for this employee.

Name: _____ **Diagnosis:** _____

Date of visit: _____ Date of next visit: _____ **Date of injury:** _____

Return to work status:

☐ May return to work with no restrictions: Date: _____

☐ May NOT return to work: _____ Estimated date of return: _____

☐ May return to "Modified" work: Date: _____ Estimated duration of modified work: _____

Physical limitations: *(No comment will mean no limits)*

Definitions for physical limitations:

No limits (no restrictions) | Frequently (66% of job) | Occasional (33% of job) | Minimal (1% to 5% of job) | None (0% of job)

Capabilities	No limit	Frequently	Occasional	Minimal	None
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Reach above shoulders	☐	☐	☐	☐	☐
Use stairs/steps/step-stools	☐	☐	☐	☐	☐
Use of ladders	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Client Contact:

_____ May have unlimited contact with clients, including providing care and placing clients in approved holds

_____ May perform activities in presence of clients but no direct care

_____ May work in office which would involve being in the presence of clients going to and from office/bathroom

_____ No patient contact at all, i.e. work in administrative office or other support services

_____ Other: _____

Lifting	No limit	Frequently	Occasional	Minimal	None
0-10 lbs.	☐	☐	☐	☐	☐
11 – 20 lbs.	☐	☐	☐	☐	☐
21 – 35 lbs.	☐	☐	☐	☐	☐
36 – 50 lbs.	☐	☐	☐	☐	☐
51 – 75 lbs.	☐	☐	☐	☐	☐
Use arms: repeated push/pull	☐	☐	☐	☐	☐
Use arms: repeated grasp, lift, carry	☐	☐	☐	☐	☐
Use hands: repeated fine manipulations	☐	☐	☐	☐	☐
Carry: Give maximum OK	☐	☐	☐	☐	☐

Endurance: Our work shifts vary from 8 hours to 16 hours a day. Indicate the number of continuous hours the employee may engage in each activity _____

Continual hours sit: _____

Continual hours stand: _____

Continual hours walk: _____

Commute: Able to drive, be driven, or take public transportation to work? Yes ☐ No ☐

Medications: Taking any medications that would affect their ability to respond in an emergency or to drive a vehicle on the job? Yes ☐ No ☐

Prognosis (comments): _____

Medically Stationary: Yes ☐ No ☐ Date: _____ Are restrictions on this form permanent: Yes ☐ No ☐

Signature: _____ Date: _____

Clinic/Office: _____ Phone: _____

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Worker's Compensation
Associated Leave Choices for AFSCME and ONA

SOCP Safety Program
503-378-5952 X232
FAX: 503-378-5917

If you are on authorized SAIF time loss, you may choose one of five leave options to cover your absence from SOCP. You are to designate the option you choose within the pay period in which the compensable time loss from work begins.

- Once you have chosen an option, it will remain in place during the entire time loss period unless the agency approves a change; *or*
- In the case of ONA represented employees, once every three months a change may be made.

In the event you receive a fulltime release back to regular or modified work your leave choice will end. Should you later go back out on time loss for the same claim you must fill out a new leave choice form.

When your accumulated leave option is exhausted, you will then be placed on approved sick leave without pay, during the period in which worker's compensation is being received.

SOCP's paid leave during a worker's compensation time loss claim is equal to the difference between the SAIF check and your regular salary rate. Prorated charges will be made against accrued sick leave, vacation, personal leave, and/or compensatory time, as indicated by your choice.

Leave used as a result of an employee's absence due to a worker's compensation claim will run concurrently with FMLA/OFLA 12-week entitlement.

I have read the above material and made my choice on the reverse side of this form.

***I understand that if I do not complete this form and return it to my supervisor by the time timesheets are submitted, my supervisor will place me on sick leave without pay for the time within that pay period*.**

Employee signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

(Give a copy of this form to timekeeper)

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Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

AFSCME Employee Options

Choice (check one)

☐ **Option #1** – Use accrued sick leave

☐ **Option #2** – Use accumulated compensatory time

☐ **Option #3** – Use accrued vacation time and/or personal leave

☐ **Option #4** – Use any combination of option 1, 2 and/or 3. Record in the space below type, the amount of leave and the order in which you would like it used.

Order of use	Type	Amount of leave
1st		
2nd		
3rd		

☐ **Option #5** – Do not use any accumulated leave time. Place me on approved sick leave without pay status.

PRINT Employee name _____ *Date of injury* _____ *Employee ID number* _____

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State Operated Community Program

ONA Employee Options

Choice (check one)

☐ **Option #1** – Use accrued sick leave

☐ **Option #2** – Use accumulated compensatory time

☐ **Option #3** – Use accrued vacation time and/or personal leave

☐ **Option #4** – Use any combination of Option 1, 2 and/or 3. Record in the space below type, the amount of leave and the order in which you would like it used.

Order of use	Type	Amount of leave
1st		
2nd		
3rd		

☐ **Option #5** – Do not use any accumulated leave time. Place me on approved sick leave without pay status.

PRINT Employee name _____ *Date of injury* _____ *Employee ID number* _____

Interoffice Memorandum
STATE OPERATED COMMUNITY PROGRAM
Seniors and People with Disabilities
Department of Human Services
P.O. Box 14680, Salem, Oregon 97309-0449

Date _____, 2011

To: Office Human Resources
State Operated Community Program

From: _____
Employee name (please print)

Subject: **IN & OUT OF HOUSE POSTINGS**
While out on **(DS/SAIF)** Leave I, _____
(name)

_____ _____
Employee current address *Home phone:*

_____
E-Mail address(if applies)

This form ***only*** applies to employees absent from work due to **job incurred injuries** or **duty stationed at home (DS)** and needs to be **returned to HR within 5 days** from the date your SAIF forms are tuned in ***or*** from the date a letter for DS has been received. HR will not be responsible for any missed postings if this form is not return in a timely manner.

Mark all that apply:

☐ **Do Not** want to be notified of any **In & Out** of house vacancy postings.

☐ **Would like** to be notified of **In House** vacancy posting only.

☐ **Would like** to be notified of **Out of House** vacancy postings only. (If only certain Homes or certain shifts, be specific.)

_____

I understand that if I elect to be notified, the Office of Human Resources will mail, e-mail, or phone the information to me.

Signature: _____ Date: _____
(not valid without)

HR is not responsible for the notification of current postings if the absence form work is due to a Non-Job Injury, FMLA/OFLA Leave or Vacation Leave.