Injured Worker Packet

Process & Procedure Guide

What to do when an employee is injured on-the-job

If Employee does NOT Seek Medical Attention	**Employee:** complete ONLY the /// Ly̓dzǁěĸLffy̓Ŝăăĸ Ly̓ŎꞃŘŜy̓ΰ wŜǈƻǁΰ Cƻǁϒ.
	Send copy of forms to Human Resources via {ŜǁØꞃŎŜ 5Ŝăʅ or fax рлoπсрлπтoпу.
	***Do NOT complete 801 Form if no medical treatment is sought.**
If Employee DOES Seek Medical Attention	**Employee:** complete the CCC Injury/Illy̓Ŝsă/Incidey̓ΰ ReǈJort Formΰ
	Employee: complete, sign and date 801 form.
	Employee: read and sign the CCC Return-to-Work Program
	Send copy of forms to Human Resources via {ŜǁØꞃŎŜ 5Ŝăʅ or fax 503π650-7348.
	***Immediately notify Human Resources (503-594-3oлл) if emǈJloyeŜ is hospitalized overnight.**
Before Employee Seeks Medical Attention	**Supervisor:** give Guide for Workers Recently Hurt on the Job to employee.
	Supervisor: give a copy of this page to employee.
	Supervisor: give Return-to-Work Status form to employee to take to healthcare provider.
	*If injury is serious and completing forms prior to seeking medical treatment is not reasonable, Supervisor to complete what they can and turn in as outlined above. Employee complete & sign copy of 801 as soon as reasonably possible.
While Employee Seeks Medical Attention	**Employee:** discuss physical requirements of your normal job with doctor and have them complete the Return-to-Work Status form.
	Employee: communicate your work status and submit forms to your supervisor.
	Employee: continue to bring work releases to supervisor after every healthcare provider's visit.
After Employee Returns from Seeking Medical Attention	**Supervisor:** send completed copies of Return-to-Work Status form and any other healthcare provider's notes to HR via {ŜǁØꞃŎŜ 5Ŝăʅ ƻǁ ŦI·Ȅ рлoπсрлπ7348.
	Supervisor: give copies of Return-to-Work Status form to employee.
	Supervisor: read Return-to-Work Status form and healthcare provider's notes to arrange for appropriate modified duty if employee is released to modified duty.
	Supervisor: continue to send copies of subsequent healthcare provider's releases to Human Resources after each time the employee seeks medical attention.
	Supervisor: notify Human Resources immediately of any changes in employee's work status (stop/start of: time loss, modified duty, or regular duty.)
	****Contact*** Human Resources with any questions about employee's work status.
If Employee CANNOT Work Due to Injury	**Employee:** provide documentation from healthcare provider to Supervisor or Human Resources authorizing absence from regular AND modified duty.
	Human Resources: provide injured employee with information regarding protected leave.
	Employee: communicate with Human Resources while on protected leave.

A guide for workers recently hurt on the job

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

saifcorporation
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 Corporation or your employer should be able to answer your questions. Call SAIF Corporation 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).

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Return-to-Work Program

Note: *This document is not designed as a substitute for reasonable accommodation under any applicable federal or state laws, such as Americans with Disabilities Act, The Rehabilitation Act of 1973, or other applicable laws.*

To preserve the ability to meet operational needs under changing conditions, Clackamas Community College reserves the right to revoke, change, or supplement guidelines at any time with written notice. The policies and procedures in this return-to-work program are not intended to be contractual commitments and they shall not be construed as such by our employees. This policy is not intended as a guarantee of continuity of benefits or rights. No permanent employment for any term is intended or can be implied by this policy.

Objectives

Clackamas Community College (the College) has developed a return-to-work program. Its purpose is to return workers to employment at the earliest date following any work-related injury or illness. We desire to speed recovery from work-related injury or illness and reduce insurance costs. This program applies to all workers and will be followed whenever appropriate.

The College defines "transitional" work as temporary modified work assignments within the worker's physical abilities, knowledge, and skills.

Where feasible, transitional positions will be made available to injured employees in order to minimize or eliminate time loss.

For any operational reason, at any time, we may elect to change the working shift of any employee based on the business needs of this company.

The physical requirements of transitional/temporary work will be provided to the attending physician. Transitional/temporary positions are then developed with consideration of the worker's physical abilities, the operational needs of the College, and the availability of transitional work.

Transitional temporary work assignment

The College will determine appropriate work hours, shifts, duration, and locations of all work assignments. The College reserves the right to determine the availability, appropriateness, and continuation of all transitional assignments and job offers.

Communication

It is the responsibility of the worker and/or supervisor to immediately notify Human Resources of any changes concerning a transitional/temporary work assignment. Human Resources will then communicate with the insurance carrier and attending physician as applicable.

Employee responsibilities

Accident reporting

- An accident is any unplanned event that disrupts normal work activities and may or may not result in injury or property damage. All work-related accidents, injuries, and near misses must be reported immediately to Human Resources.
- If an accident occurs, but **does not** require professional medical treatment, the supervisor should immediately be informed so that an accident investigation can be completed. If first-aid treatment is needed, it should be sought on-site.

- If an accident occurs which requires professional medical treatment, the worker should follow the emergency response plan. The worker must fill out a workers' compensation 801 form as soon as possible.

Worker's physical condition

- If professional medical treatment is sought, the worker should inform the attending physician that the College has a return-to-work program with light duty/modified assignments available.
- The worker will be provided with a **Return-to-Work Status** form. This should be provided to the treating physician and should be returned to Human Resources following the initial medical treatment.

Worker able to return to work

- If the attending physician releases the worker to return to work, as evidenced by completion of a **Return-to-Work Status** form, the form must be returned to Human Resources within 24 hours for assignment of light duty/modified work. The worker must report for work at the designated time.
- The **worker cannot return to work without a release** from the attending physician.
- If the worker returns to a transitional/temporary job, the worker must make sure that he or she does not go beyond either the duties of the job or the physician's restrictions. If the worker's restrictions change at any time, he or she must notify his or her supervisor at once and give the supervisor a copy of the new medical release.
- The injured worker is encouraged to schedule physical therapy and medical appointments at times when the worker is not expected to be at work.

Worker unable to return to work

- If the worker is unable to report for any kind of work, the worker must call in at least weekly to report medical status.
- In order to receive time loss benefits, any medical absence from work related to an injury requires an authorization for the worker's attending physician.
- While off work, it is the responsibility of the worker to supply Human Resources with a current telephone number (listed or unlisted) and an address where the worker can be reached.
- The worker will notify Human Resources within 24 hours of all changes in medical condition.

Employer responsibilities

Accident reporting

- The supervisor will conduct an accident investigation on all accidents, regardless of whether an injury occurs.
- When an accident occurs which results in injury requiring **professional medical treatment,** Human Resources will forward a completed workers' compensation **801** form to the insurance carrier within five (5) calendar days of knowledge of the injury or illness.
- Other information will be forwarded as soon as developed, including:
    - Name of worker's attending physician
    - Completed **Return-to-Work Status** form from attending physician and medical documentation, if appropriate
    - Completed transitional/modified or regular **Job Description**
    - **Job Offer** letter and responses

- Human Resources will notify the insurance carrier of any changes in the worker's medical or work status as soon as possible.

Medical treatment and temporary/transitional duty physical condition

- At the time of first medical treatment the **Return-to-Work Status** form must be completed and returned to Human Resources. If one is not, Human Resources will request one from the attending physician.
- For subsequent medical treatment, a **Return-to-Work Status** form and a completed **Job Description** form (if available) will be provided to the worker to take to the attending physician for completion and/or approval.
- The completed **Return-to-Work Status** form will be reviewed by Human Resources. A temporary/transitional **Job Description** form will be prepared from information obtained from the attending physician for review and approval.

Job Offer letter

- Upon receipt of a signed temporary/transitional **Job Description** form from the attending physician, a written **Job Offer** letter will be prepared by the employer. It will be mailed by both regular and certified mail to the worker's last known address or presented to the worker.
- The letter will note the physician's approval and will explain the job duties, report date, wage, hours, report time duration of transitional work assignment, phone number, and location of the transitional assignment.
- The worker will be asked to sign the bottom of the **Job Offer** letter indicating acceptance or refusal of the offered work assignment.
- Copies of the **Job Description, Work Releases**, and **Job Offer** letters will be forwarded to the insurance carrier.

Supervisor

- The supervisor will monitor the injured worker's performance to ensure the worker does not exceed the worker's physician release.
- The supervisor will monitor the injured worker's recovery progress through regular contact to assess when and how often duties may be changed. The supervisor will assess the College's ability to adjust work assignments upon receipt of changes in physical capacities.

Worker acknowledgment

- The return-to-work program and procedures have been explained to me.
- I have read and fully understand all procedures and responsibilities.
- I agree to observe and follow these procedures.
- I have received a copy of this program and procedure.
- I understand failure to follow these procedures may affect my re-employment, reinstatement, and vocational assistance rights.

_____

Worker signature Date

saifcorporation
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

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. 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:** Emp
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.		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
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)				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. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	13. Birthdate:	14. Gender: ☐ M ☐ F
15. Your mailing address, city, state and zip:			16. Home phone:
17. Social Security no. (see back*):	18. Occupation:		19. Work phone:
20. Names of witnesses:			
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.

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

30. Employer legal business name:		31. Phone:	32. FEIN:
33. If worker leasing company, list client business name:			34. Client FEIN:
35. Address of principal place of business (not P.O. Box):			36. Insurance policy no.:
37. Street address from which worker is/was supervised:	ZIP:		38. Nature of business in which worker is/was supervised:
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:	50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
51. Employer signature:	52. Name and title (please print):		53. Date:

801
X801 3/16

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

RESET PRINT

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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 (01/16/DCBS/WCD/WEB) for distribution with X801 SAIF Corporation 3/16

Injury/Illness/Incident Report Form

Instructions: CCC students, employees, and visitors shall use this form to report all injuries, illnesses, or "near miss" events (which could have caused an injury or illness) on campus—*no matter how minor*.

*If you are and employee and will be seeking medical treatment, you **MUST** complete an injured worker packet as soon as possible. Contact Human Resources (HR) or your Supervisor for additional information.*

Name of Injured Person: _____

Relationship to the College: ☐ Employee ☐ Student ☐ Visitor ☐ Public ☐ Other: _____

Primary Phone (Personal): _____ **Work Phone:** _____

Date of Injury: _____ **Time of Injury:** _____ ☐ am ☐ pm

Specific Location of Injury: _____ **Campus:** ☐ Oregon City ☐ Harmony
(i.e. building name, room number) ☐ Wilsonville ☐ Other

Transported for Medical Treatment? ☐ Yes ☐ No **If Yes, By Whom?** _____

Was 911 Called? ☐ Yes ☐ No

*For liability reasons, CCC staff **CANNOT** transport an injured or ill person.*

Please describe, in detail, what happened (attach another sheet if necessary)**:**

_____

_____

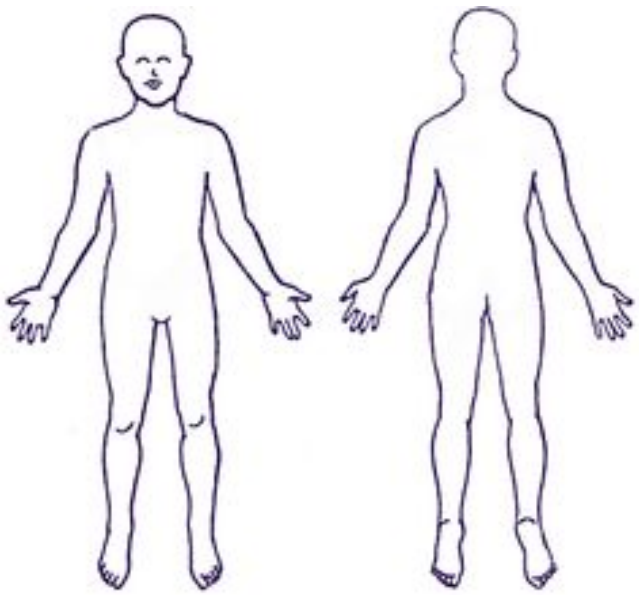
_____

_____

Please indicate where you are injured

Please check all body parts that apply and mark on diagram

☐	Head/Neck		
☐	Shoulder	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right
☐	Elbow	☐ Left	☐ Right
☐	Forearm	☐ Left	☐ Right
☐	Wrist/Hand	☐ Left	☐ Right
☐	Abdomen	☐ Left	☐ Right
☐	Chest	☐ Left	☐ Right
☐	Back	☐ Upper	☐ Lower
☐	Hips	☐ Left	☐ Right
☐	Thigh	☐ Left	☐ Right
☐	Lower Leg	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right
☐	Ankle/Foot	☐ Left	☐ Right
☐	Other (describe): _____		



Witness Information:

_____ _____
Printed Name **Phone Number**

_____ _____
Printed Name **Phone Number**

_____ _____
Injured Person Signature **Date**

☐ Check if injured person is unable to sign.

Submit completed form to HR ASAP at Barlow Hall 204 or via the HR Service Desk at http://support.clackamas.edu

Rev. 11/2021

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.: _____