



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

# Report of Job Injury or Illness

Workers' compensation claim

## Worker

Complete this form and give a copy to your employer if it is your intention to file a claim for Workers' Compensation Benefits for this injury/disease.

<b>NAME: (Last, first, middle)</b>			<b>JOB TITLE:</b>		
1. Date of injury or illness:	2. Date you left work:	3. Shift on (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. day of injury: (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		4. Regularly scheduled days off: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S	
5. Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	6. Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	7. Check here if you are employed by more than one employer: <input type="checkbox"/>			
8. What is your illness or injury? What part of the body? Which side? <input type="checkbox"/> Left <input type="checkbox"/> Right (Example: sprained right foot)			9. Workers' language preference other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> 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 carry a 40 lb. box of roofing materials)					
11. Name of Witnesses:			12. Have you previously injured or sought treatment for this body part? <input type="checkbox"/> No <input type="checkbox"/> Yes		
13. Your legal name:			14. Birthdate:	15. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
16. Mailing address, city, state and zip:				17. Home Phone:	
18. SSN :		19. Dept.:		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? <input type="checkbox"/> No <input type="checkbox"/> Yes					
24. Were you treated in the emergency room? <input type="checkbox"/> No <input type="checkbox"/> Yes					
25. <b>By my signature</b> , 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, insurers, self-insured employers and claims administrators to release relevant medical records and claim records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. <b>Notice:</b> Relevant medical records and claim records include records of prior treatment and claims for related conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization. <b>I certify, as attested by my signature and under penalty of law that all information I have given is true and contains no false statements and/or misrepresentations.</b>					
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 and maintain a copy for your records. Notify CIS within five days of knowledge of the claim.

29. <b>Employer legal Business name:</b>		30. Phone:	31. FEIN:
32. If worker leasing company, List client business name:		33. Client FEIN:	
34. Address of principal place of business (not P.O. box):		35. Insurance policy no.:	
36. Street address from which Worker is/was supervised:		ZIP:	37. Nature of business in which worker is/was supervised:
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			40. NCCI code:
41. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	42. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No		43. OSHA 300 log case #:
44. <b>Date employer knew of claim:</b>	45. Worker's weekly wage: \$	46. Date worker hired:	47. If fatal, date of death:
48. <b>Return-to-work status:</b> <input type="checkbox"/> Not returned <input type="checkbox"/> Regular Date: <input type="checkbox"/> Modified Date:			49. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
50. Employer signature:	51. Name, title and phone (print):		52. Date: