



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.

NAME: (Last, first, middle)			JOB TITLE:		
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? No <input type="checkbox"/> Yes <input type="checkbox"/>		
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. 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, 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. Notice: 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. 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.					
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. Employer legal Business name: City of Springfield		30. Phone: 541-726-3788	31. FEIN: 936002258
32. If worker leasing company, List client business name: NA		33. Client FEIN:	
34. Address of principal place of business (not P.O. box): 225 5th Street, Springfield, OR 97477		35. Insurance policy no.: 5602347	
36. Street address from which Worker is/was supervised: ZIP: 97477		37. Nature of business in which worker is/was supervised: Municipality	
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. Date employer knew of claim:		45. Worker's weekly wage: \$	46. Date worker hired:
47. If fatal, date of death:		48. Return-to-work status: <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:	