

OREGON MILITARY DEPARTMENT INJURED WORKER PACKET

Dear _____ Date of Injury _____

This packet has been prepared to assist you in obtaining the best medical treatment as well as provide a smooth transition in your return to regular work should there be a need to place you in a temporary modified job assignment. Your claim will be managed by SAIF Corporation, our workers' compensation insurance carrier, for processing.

SAIF will evaluate your claim and determine if it is job related. After a review of your claim, a SAIF representative will contact you. If you have any questions regarding your claim or the workers' compensation process, they will gladly assist you. If you receive medical bills regarding your claim, please send them directly to SAIF. If you have any unanswered questions, feel free to discuss them with your supervisor or the Safety Manager.

If you are unable to immediately return to your regular duties, your supervisor will work with you and your physician to allow you to return to temporary modified / transitional work as part of your rehabilitation. In this process, you may be assigned to temporary modified / transitional job tasks that are within the physical restrictions stated by your physician. This packet contains a **Release To Return-To-Work** form that you must take with you each time you see your doctor. It is important that you have your doctor complete the form during each visit and return it immediately to your supervisor. This form must be forwarded to the Safety Manager to forward to SAIF. **Make extra copies for future visits if needed.**

NOTE: In accordance with AGP "Early Return to Work", (AGP 99.100.06), temporary modified / transitional job assignments are managed on a case-by-case basis and will be re-evaluated every 30 days with the goal of a return to full performance of essential job functions within 90 days.

To assure that your claim is handled properly and you receive appropriate benefits, it is important that you follow the guidelines contained in the enclosed Injured Workers' Responsibilities document. Please read it carefully. Send copies of the completed forms to the Safety Manager. Additionally, you must properly code your time sheet for time loss or modified work performed as a result of your injury using the enclosed **Time Sheet Codes List**.

You are encouraged to keep all correspondence relating to your claim together for future reference.

We wish you a successful and speedy recovery.

Sincerely,

/s/

Robin Webb
OMD Safety Manager
503-584-3581

Contents: Supervisor's Responsibility Checklist for Injured Worker ERTW
Injured Workers' Responsibilities
Injured Workers' Responsibilities Checklist
Time Sheet Code List
Notice of Employee Rights and Responsibilities (must be completed and signed)
Form 801 (all information provided and signed by employee and supervisor)
CBIW Notification Form
Release to Return-to-Work form (must be completed for each visit to doctor)
Report of Incident/Accident/Illness form
Employee Leave Request/Record
Temporary Modified/Transitional-Duty Assignment Letter (completed by Supervisor)

The following forms are to be used in the event of temporary modified / transitional job duty

Job Description form (when needed to communicate with doctor, work with Safety Manager to complete)

SUPERVISOR'S RESPONSIBILITIES CHECKLIST FOR INJURED WORKERS' EARLY RETURN TO WORK

- ❑ Assist the injured worker in completing and signing an Accident/Illness Report form and SAIF 801 workers' compensation form (<http://www.oregon.gov/OMD/AGP/docs/workerscomp/Military-801.pdf>).
- ❑ If an employee is injured and is unavailable to complete the 801, complete the employee section of the report and send it to AGP as soon as possible. Do not hold the form for the employee's signature. The SAIF Corporation claims adjuster will obtain the additional information not provided by the employee.
- ❑ The 801 must be received by SAIF within 3 days of the incident.
- ❑ Contact the Safety Manager to assist with the workers' compensation and early return to work process.
- ❑ If the employee is seeking medical attention, provide them with the Release to Return to Work form. (included in this packet)
- ❑ Instruct the injured worker to return the Release to Return to Work form to you immediately following the doctor's appointment. This form provides:
 - a release to perform the worker's regular job, OR
 - a release to perform temporary modified / transitional job tasks with limitations specified by the doctor on the form, OR
 - no release for return to work.
- ❑ If the employee was given an immediate release to regular work by their doctor, **NO FURTHER ACTION IS NECESSARY other than sending/faxing a copy to AGP.**
- ❑ If the employee is released for temporary modified / transitional job tasks, identify tasks the employee can perform considering the limitations the doctor has noted.
- ❑ Contact the Safety Manager and discuss the temporary modified / transitional job tasks. Immediately complete and fax the Job Description and doctor's Release to Return to Work form to the Safety Manager at 503-584-3556.
- ❑ In the event it becomes necessary to make a bonafide job offer, contact the Safety Manager at 503-584-3581. As the injured worker heals, the regular tasks can be added with doctor approval. Review the injured worker's progress routinely, at least every 30 days. **In accordance with AGP Policy 99.100.06 "Early Return to Work", temporary modified / transitional jobs assignments are managed on a case-by-case basis and will be re-evaluated every 30 days with the goal of a return to full performance of essential job functions within 90 days.**
- ❑ Complete the Temporary Modified/Transitional Duty Assignment letter. Give copy to Employee and send/fax/scan original to the Safety Manager (Included in this packet).
- ❑ Instruct the injured worker to work within the doctor's restrictions. Monitor the injured worker's progress; revise the temporary modified / transitional job tasks as the worker progresses toward release to regular duties.
- ❑ If the injured worker is not released to regular or temporary modified / transitional work, call the Safety Manager at 503-584-3581 within 24 hours to discuss the conditions under which the employee can return to work and when. **Every attempt should be made to return the employee to work in 3 days or less.** If a release is negotiated, perform the steps above.
- ❑ If the injured worker is not released to return to work, the worker must maintain *weekly* contact or as directed by the supervisor.
- ❑ The injured worker must provide an updated Release to Return to Work form within 24 hours following each visit to their doctor.

INJURED WORKER'S RESPONSIBILITIES

The Oregon Military Department (OMD) has an Early Return-to-Work Program designed to assist you in recovery from your on-the-job injury. (See AGP Policy 99.100.06). Failure to follow the guidelines may affect your benefits under the Workers' Compensation Law. If you have any questions or concerns about your responsibilities, please contact your supervisor or the Safety Manager.

KEEP YOUR SUPERVISOR INFORMED

It is important to keep your supervisor informed at all times about your medical condition and your return-to-work status. You must present a **Release To Return-To-Work** form (included in this packet) to your doctor during each visit and ask him/her to complete the form before you leave.

If you **ARE RELEASED** for regular or temporary modified / transitional job tasks:

1. Submit the completed **Release To Return-To-Work** form to your supervisor within **24** hours of your visit.
2. Work with your supervisor to develop a temporary modified / transitional work assignment if any temporary modified restrictions exist.
3. Perform temporary modified / transitional job tasks consistent with restrictions outlined by the physician.
4. Continue to provide completed **Release To Return-To-Work** forms to your supervisor after each doctor's visit until medically stationary.

Note: Temporary modified / transitional work assignments are managed on a case-by-case basis and will be re-evaluated every 30 days. Temporary modified / transitional work assignments will not exceed 90 days in length unless authorized by the Safety Manager. Permanent impairment that affects your ability to perform regular job duties is outside the scope of this program. If permanent restrictions result from your injury that precludes you from performing regular job duties, report them to your supervisor immediately.

5. Make arrangements with your supervisor for follow-up visits for medical services related to your injury that are scheduled during working hours.
6. Code your timesheet as indicated on the ***Time Sheet Code*** list in this packet.

If you **ARE NOT RELEASED** for regular or temporary modified / transitional work:

1. Submit a **Release To Return-To-Work** form to your supervisor after each visit to the doctor.
2. Present any information from your physician indicating your status to your supervisor.
3. Your doctor must provide written authorization for all time loss. The properly completed **Release To Return-To-Work** form fulfills this requirement.
4. If you are off work because of your injury, you must contact your supervisor at least weekly or as agreed by your supervisor.
5. You must keep your supervisor informed of your current address and phone number (even if unlisted).

INJURED WORKER RESPONSIBILITIES CHECKLIST

EMPLOYEE AND SUPERVISOR SHOULD USE THIS CHECKLIST TO ENSURE PROPER HANDLING OF THE CLAIM

- ❑ Report all incidents to your supervisor immediately, even if no one is injured. If unable to report immediately, report no later than the end of the work shift.
- ❑ Employee assists supervisor in completing an Accident & Illness Report form.
- ❑ If Employee needs and seeks medical treatment for work related injury/illness:
 - Employee completes and signs the Worker's section of the SAIF 801 report of injury form (<http://www.oregon.gov/OMD/AGP/docs/workerscomp/Military-801.pdf>) and gives to supervisor. The employee's supervisor shall fax the completed forms to the Safety Manager at 503-584-3556.
- ❑ Employee gives attending doctor the **Release to Return-to-Work** form for completion.
- ❑ Employee returns the completed **Release to Return-to-Work** form to the supervisor following the doctor's appointment but no later than the next business day. **The employee has the treating physician complete a new form after each medical visit.**
- ❑ Employee gives the written doctor's release for regular or temporary modified / transitional work immediately to the supervisor and reports to work as directed.

Note: Temporary modified / transitional work assignments are managed on a case-by-case basis and will be re-evaluated every 30 days. Temporary modified / transitional work assignments will not exceed 90 days in length unless authorized by the Safety Manager. Permanent impairment that affects your ability to perform regular job duties is outside the scope of this program. If permanent restrictions result from your injury that precludes you from performing regular job duties, report them to your supervisor.

- ❑ If the employee is not released to work, the employee must report to supervisor at least *weekly* or as directed by the supervisor.
- ❑ Employee records all injury-related leave time using the correct time sheet codes.
- ❑ Employee keeps the supervisor and the Safety Manager informed at all times of current address, home phone number, or other phone number where worker may be reached.

TIME SHEET CODES

**TO BE USED BY EMPLOYEES WHILE OFF DUE TO
AN ON-THE-JOB INJURY**

SL3 – Sick leave

VA3 – Vacation leave

PB3 – Personal Business

LO3 – Leave without pay

CT3 – Comp time leave

FL3 – Bereavement Leave

GL3 – Governor’s Leave

HO3 – Holiday Leave

RGM – Regular Modified Light Duty Hours – This code is to be used when employees work modified duties.

**NOTICE OF EMPLOYEE RIGHTS AND RESPONSIBILITIES
IN THE EVENT OF A WORKPLACE ACCIDENT, INJURY OR ILLNESS**

******* The injured worker must read and sign this form *******

EMPLOYEE NAME: _____ Location: _____ DATE OF INJURY: _____

1. Report all incidents to your supervisor immediately, even if no one is injured. If unable to report immediately, report no later than the end of the work shift.
2. Cooperate and/or participate in the analysis and system improvements of all incidents.
3. If you are injured, you must complete an **Accident & Illness Report** form before the end of your work shift.
4. If you are injured and want to see a doctor, you must also:
 - ◆ Complete the Worker's section of Form 801.
 - ◆ Have your doctor complete the **Release to Return-to-Work** form for authorized leave or temporary modified / transitional work at the time of your first visit.
 - ◆ Give the **Release to Return-to-Work** form completed by your doctor to your supervisor immediately after the doctor's visit, but no later than 24 hours.
5. If you are not able to immediately return to your regular job, your supervisor will determine if there is temporary modified / transitional job tasks available for you. This assignment will begin immediately upon receipt of the **Release to Return to Work** form and last until one of the following occurs:
 - ◆ A thirty-day review indicates you are not progressing to release to regular work.
 - ◆ Your doctor indicates you have permanent restrictions that will prevent you from returning to your regular job.
 - ◆ Appropriate temporary modified / transitional job tasks are no longer available.
 - ◆ Your doctor releases you for regular work.
 - ◆ Your claim for workers' compensation benefits is denied.
6. If your doctor does not release you immediately for any work or your temporary modified / transitional work has expired, you shall:
 - ◆ Maintain regular contact with your supervisor as assigned, at least weekly.
 - ◆ Provide the **Release to Return-to-Work** form completed by your doctor after each visit. This will constitute your medical leave authorization. **ONLY THIS FORM, OR ONE WITH SIMILAR INFORMATION FROM YOUR DOCTOR, WILL BE ACCEPTED AS DOCUMENTATION OF AUTHORIZED MEDICAL LEAVE.**
 - ◆ Select leave choice option and notify your supervisor.
 - ◆ Submit your selection of continued health benefits per the CBIW notice you received in the Injured Worker Packet (OAR 659A.063–659A.069)
<http://www.leg.state.or.us/ors/659a.html>.
 - ◆ Provide the agency with a current address and phone number at all times.

7. When your doctor releases you for any type of work, you must notify your supervisor immediately, but no later than the *first* regular workday following the release.
8. *If you have been determined, by your treating physician, to have permanent restrictions which preclude you from returning to the job you held at injury, but you are available to work, you will need to work with the Safety Manager to identify other suitable and available work which you are qualified to perform.*
9. Once suitable work is offered to you (see # 8 above), you must respond within seven (7) days.

YOU HAVE A RIGHT TO RETURN TO YOUR JOB AT INJURY WITHIN THREE YEARS FROM THE DATE OF INJURY, IF YOU ARE RELEASED TO DO SO BY YOUR DOCTOR, ORS 659A.043 & 659A.046 <http://www.leg.state.or.us/ors/659a.html> .

YOU HAVE A RIGHT TO KNOW THE STATUS OF YOUR CLAIM.

YOU HAVE A RIGHT TO KNOW YOUR EMPLOYMENT AND BENEFIT STATUS.

For information regarding your claim, contact SAIF at 503-373-8000 or 800-285-8525. Have your SAIF Claim Number or SS Number available. If you have a question regarding your employment, contact your supervisor or AGP at 503-584-3581.

Fax numbers:

AGP: 503-584-3556

SAIF Claims: 800-475-7785

I have read the above information. I understand my responsibilities. I will call the appropriate parties to obtain more information or clarification if I have questions.

Employee Signature and Date

Supervisor Signature and Date

Note To Supervisor

GIVE ONE COPY TO EMPLOYEE
SEND ORIGINAL TO SAFETY MANAGER - AGP
RETAIN COPY IN SUPERVISOR WORKING FILE

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

For SAIF Customer Use

Area _____
Dept. _____
Shift _____ CC _____

CLAIM NO. _____
SUBJECT DATE _____
CLASS _____
DEFAULT DATE _____
EMPLOYER'S ACCOUNT NO. _____

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. Shift on day of injury: (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	4. Regularly scheduled days off: <input type="checkbox"/> <input type="checkbox"/> M T W T F S 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? (Example: sprained right foot)		9. Worker's 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 carrying a 40-lb. box of roofing materials)			
11. Name of witnesses:		12. Have you previously injured this body part? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 (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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> .)			
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: Oregon Military Department		30. Phone: AGP (503) 584-3581	31. FEIN: 93-6001775
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): 1776 Militia Way SE, Salem, OR 97309		35. Insurance policy no.: 155927	
36. Street address from which worker is/was supervised: ZIP:		37. Nature of business in which worker is/was supervised: Government	
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. Class code: 9499	
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 <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 (please print): Robin Webb, Safety Officer (503) 584-3581	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

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.

CBIW NOTIFICATION FORM

** IMPORTANT EMPLOYEE NOTICE **

State Law ORS 659A.060-659A.066 (CBIW) requires the State as an employer to continue to pay the employer's contribution toward health and dental benefits when coverage under a State plan would otherwise end due to a workers' compensation injury or illness. Failure to continue health and dental benefits for injured or ill workers as provided under ORS 659A.060-659A.066 (CBIW) is an unlawful employment practice. This notice informs you of your rights and obligations under the provisions of this law.

If eligible for continuation of coverage under this law, you will receive the coverage that you had immediately before your on-the-job injury or illness. The law requires that the agency maintain your coverage up to twelve months from the date of knowledge of the injury or illness. However, the law also provides that the agency can end your coverage early for any of the following reasons:

- a) Your attending physician has decided that you are medically stationary and your claim has been closed;
- b) You return-to-work for any agency of the State after a period of continued coverage under this law, and satisfy any probationary or minimum work requirement to be eligible for group health benefits;
- c) You take full or part-time employment with a private or public employer other than the State of Oregon that is comparable in terms of the number of hours per week you were employed with the State, or you retire;
- d) Twelve months have elapsed since the date the State received notice that you filed a workers' compensation claim;
- e) SAIF denies your claim and you fail to appeal within 60 days or, if you appealed, the Workers' Compensation Board, a workers' compensation hearing referee or a court decides that your claim is not compensable.
- f) You do not pay the required premium, or portion thereof, in a timely manner.
- g) You elect to discontinue this coverage and notify your personnel, payroll, or campus benefits office of this election in writing.
- h) Your attending physician has released you to modified or regular work, you have been offered the work and you refuse to work; or,
- i) Employment with the State ends for reasons unrelated to the workers' compensation claim.

If the employer contribution does not cover the full cost of your health and dental premiums, you will be required to pay a portion of the premium to continue coverage. If you fail to make timely payment of any premium contribution owing, you will be notified of the 30-day grace period allowed before cancellation of your coverage. Upon expiration of your coverage under State law, you may be eligible to continue coverage on a self-pay basis under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If SAIF denies your workers' compensation claim, or if you appeal and do not prevail, the State may recover the amount of premiums paid under this law, plus interest. The State may recover the payments through a payroll deduction not to exceed 10% of your gross pay.

If you choose not to receive continued coverage under ORS 659A.060-659A.066, you may be eligible under the federal COBRA regulations to continue your medical and dental coverage on a self-pay basis for up to 18 months. Premiums for coverage continued under the COBRA provisions are set at 102% of the active group rate for the first 18 months. If Social Security determines disability at the time of your qualifying event or within the first 60 days of your COBRA coverage, you may be entitled to an extension of 11 months, for a total of up to 29 months. If eligible for the extended coverage due to a disability, premiums for months 19 through 29 will be set at 150% of the active group rate. If you would like more information on COBRA, contact your personnel, payroll or campus benefits office.

State law does not require continuation of any life or disability programs, opt-out bonus, or benefit dollars taken as cash. If you would like more information on how to continue life and disability coverage, please contact your personnel, payroll or campus benefits office. You must self-pay the Long-term Disability (LTD) premiums throughout the elimination period to be eligible for benefits. To continue other benefit plans, such as credit union or automobile insurance, you must contact the company(s) to arrange for continuation of your monthly payments.

REINSTATEMENT OF COVERAGE WHEN YOU RETURN TO BENEFIT ELIGIBLE STATUS

All benefits in effect before qualifying for coverage under ORS 659A.060-659A.066 (CBIW) will be automatically reinstated. We request that you complete the necessary Update Forms during the first 60 days of your return to assure that coverage is reinstated promptly. Changes in elections are limited to open enrollment periods or within 60 days following a qualified family status change. See your PEBB Eligibility Handbook for more information on qualified family status change.

Employees who return to benefit eligible status following a leave under ORS 659A.060-659A.066 (CBIW) are not required to work at least half time to be eligible for benefits the following month if all provisions of ORS 659A.060-659A.066 (CBIW) are met. Half time is defined as 20 hours per week and no less than 80 hours per month; .5 FTE for OUS employees or as defined by collective bargaining.

If coverage under the short or long term disability plans lapse for 90 days or more, you may be subject to new pre-existing condition limitations or waiting periods. For more information, see your PEBB Eligibility Handbook.

Return form to:
AGP, 503-584-3556 (FAX)

RELEASE TO RETURN TO WORK

Name of worker	Claim number
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Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? Yes No If yes, date: _____ (Provide closing information and complete Form 827.)
 If no, estimated medically stationary date: _____ Are there permanent restrictions? Yes No Unknown

Next scheduled appointment date: _____

2. Worker is released to:

- full duty without limitations Date: _____ (Do not complete lines 3 through 11. Sign below.)
 modified duty from (date): _____ through (date): _____ (specify limitations below)
 modified hours specify hours: _____ from (date): _____ through (date): _____
 not released to work Est. RTW date: _____ If modified release, provide date of anticipated regular release: _____

	Hours: No limitations	1	2	3	4	5	6	7	8	Other (specify)
3. In a/an <input type="checkbox"/> 8 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> other _____ -hour workday, worker can stand/walk a total of _____	<input type="checkbox"/>									
4. At one time, worker can stand/walk _____	<input type="checkbox"/>									
5. In a/an <input type="checkbox"/> 8 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> other _____ -hour workday, worker can sit a total of _____	<input type="checkbox"/>									
6. At one time, worker can sit _____	<input type="checkbox"/>									

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100	
Occasionally	<input type="checkbox"/>																					
Frequently	<input type="checkbox"/>																					

8. Worker can use hands for repetitive:
- | | | | |
|------------------------|--|--|--|
| | Right | Left | |
| a. Fine manipulation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dominant hand |
| b. Pushing and pulling | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| c. Simple grasping | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| d. Keyboarding | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): Yes No

	Continuous 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Stoop/bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of medical service provider*	Printed name	Date
--	--------------	------

440-3245 (10/05/DCBS/WCD/WEB)

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.

- Near-Miss
 - First Aid
- FILE 801, IF BOXES BELOW ARE CHECKED**
- Medical Care
 - Time Loss
 - Fatal

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 Selectio
- Tool Availability
- Maintenance
- Visual Warnings
- Guarding

Environment

What about:

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

Additional

Causal Factors:

- Faulty Equipment
 - Non-Employee
 - Prior Injury
 - Late Reporting
 - Off-the-Job Injury
- (Explain any checked boxes on separate sheet)

Supervisor's Incident/Accident Analysis

Immediate supervisor should complete this form promptly with worker.

Company Name: _____

Employee: _____

Occupation/Department: _____

Where Incident Occurred: _____ Date/Time: _____ AM/PM

If injury, describe (Nature/Body part) _____

Treatment: None First Aid Only Doctor Hospital

Treating Physician: _____

Phone: _____

Witnesses: _____

Supervisor's description of Accident/Incident after Employee Interview:

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

Management:	Employee:
Equipment:	Environment:

List recommendations to prevent reoccurrence:	Who	By When
1.		
2.		
3.		
4.		

What corrective Action has been initiated at this point: _____

Next Line Supervisor Review (Sign & Date): _____

Safety Committee Review Date: _____

If accident/incident was caused by a person not employed by us, who?

Name: _____ Phone: _____

Date: _____

Supervisor's Signature

Note: Complete entire Workers Compensation claim (Form 801 or 801s) if injury required doctor's treatment. Form 801 or 801s must be received by SAIF within five (5) days of your knowledge of doctor treatment. If needed, complete Employer's Page (Page 1) of 801 for OSHA recordkeeping requirements.

Immediate supervisor portion continued

1. Identify all witnesses and/or interested parties that have knowledge of the accident and processes involved in said accident:

2. Witness or Interview Statements:

**If you need more room, please attach additional pages as needed to this form.

Completing the Accident/Incident Analysis

All close calls, near-misses, incidents, and accidents should be analyzed for corrective action regardless of severity. Time and distance work against a thorough analysis as most people quickly forget important facts and key details.

Distance from the incident means loss of visual information, so complete the analysis at the scene as soon as possible. This form should be completed by the immediate supervisor of the person(s) directly involved in the incident. A manager, safety committee, safety officer or analysis team can assist in the absence of the immediate supervisor. This form asks no questions other than a brief description of an injury, if one occurred. Questions often provide closed answers, so the key items on the analysis document are designed to encourage open dialogue and communication about facts and details. This is the primary opportunity for those involved to gather key information for preventing similar incidents in the future.

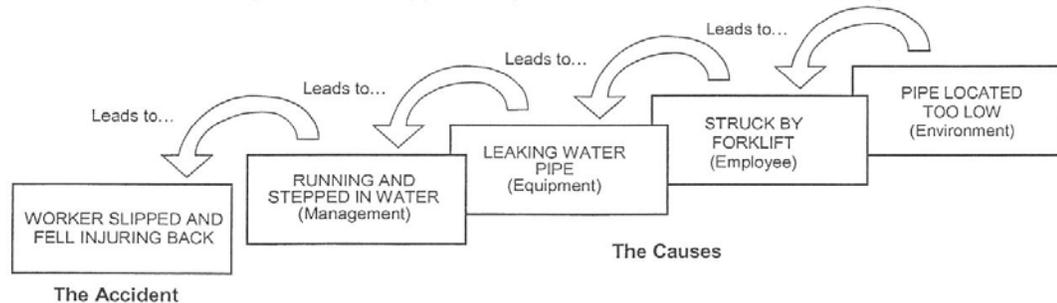
A Successful Analysis Process: The person(s) conducting the analysis need to look at the systems/procedures/policies within the business that are not working and may have contributed in some way to the incident. Even minor contributions should be listed. The systems to review are: Management, Employee, Equipment, and Environment (MEEE). Review system items shown in the left margin of the Accident/Incident Analysis form **in relation to the incident**. These are areas to explore within these systems, they are not questions. Once the contributing system elements are identified, write them in the Counter measures/best practices box along with any other system changes that will prevent recurrence.

First Step - Care for the injured: Insure appropriate medical care or first aid is provided for anyone injured.

Second Step - Secure the scene of the accident: Make certain that key evidence is preserved so that all pertinent facts of the accident can be determined. In the case of serious accidents, photographs of the scene are a valuable tool in determining causes, particularly if the area needs to be put back in order quickly. Note the position of equipment and materials, presence or lack of equipment safeguarding, specific materials and chemicals involved, warning signs and any other physical evidence.

Third Step - Interview witnesses: Witnesses to the accident or persons having knowledge valuable to the analysis should be met with individually. Emphasis should be placed on determining the facts, not on placing blame. If the injured employee(s) is/are not seriously injured, they should be interviewed while awaiting transport for medical treatment. All questions should be open-ended (who, what, when, where, how and why), to encourage a detailed account of the facts. Yes and No questions should be avoided.

Fourth Step - Analyze data to determine causes and best practices to prevent recurrence: Refer to your notes from the scene of the accident and witness interviews. Work backwards from the accident to trace all causes to their source. It is helpful to have multiple people involved in determining possible solutions. Each cause identified presents an opportunity for intervention to reduce the potential for future accidents:



Fifth Step - Follow up on corrective actions: This is usually the function of the safety officer or safety committee. At the next safety committee meeting, any accident analysis reports should be reviewed to ensure appropriate corrective actions (Countermeasures/Best Practices) were identified. Furthermore, steps should be taken to ensure that these actions have been implemented at the site of the accident as well as in any other areas appropriate in the organization. Any accidents or incidents occurring, for which a report was not completed, should be referred to the appropriate person responsible for completion of the report.

Oregon Military Department

Employee Incident/Accident Report

To be completed by employee:

1. Describe your work activity prior to and up to the time of accident.
2. Describe exactly what happened:
3. Describe what cause or causes attributed to the accident? (your actions, equipment, other factors)
4. Were you aware of the hazard prior to this incident (i.e. signs, hazard identified)? If so, describe how you became aware of it (i.e. reported to supervisor prior? If so, whom?)
5. Describe the type of medical treatment you received (if any):
Treatment: None First Aid Only Doctor Hospital
6. List any witnesses to the Incident/Accident:

JOB DESCRIPTION		REGULAR <input type="checkbox"/>	MODIFIED <input type="checkbox"/>
EMPLOYER:	Oregon Military Department	WORKER:	
ADDRESS:	ATTN: AGP PO Box 14350-AGP Salem, OR 97309-5047	ADDRESS:	
PHONE/FAX NUMBER:	(503) 584-3581 / (503) 584-3556	PHONE NUMBER:	
CONTACT PERSON:	Robin Webb	CLAIM NUMBER:	
WORKERS JOB TITLE:		HOURS PER DAY/WEEK:	
JOB DUTIES (attach narrative description if available, complete physical requirements below):			
Functions performed:			

ENDURANCE

	Never	Intermittent <1 hr	Occas. 1-3 hrs	Freq. 3-6 hrs.	Continuous 6+ hrs.	Total Hours in a work day
Sitting						
Standing						
Walking						

PHYSICAL REQUIREMENTS

	Lift										
	0 hr	Intermittent <1 hr	Occas. 1-3 hrs.	Freq. 3-6 hrs.	Cont. 6+ hrs		0 hr	Intermittent <1 hr	Occas. 1-3 hrs.	Freq. 3-6 hrs.	Cont. 6+ hrs
1-10 lbs						Bend					
11-15 lbs						Twist					
16-50 lbs						Crouch					
51-75 lbs						Kneel					
76-100 lbs						Crawl					
						Walk-Level Surface					
						Walk-Uneven Surface					
						Climb Stairs					
						Climb Ladder					
						Reach Above Shoulder					
						Use of Arms					
						Use of Wrist					
						Use of Hands					
						(a) Grasping					
						(b) Squeezing					
						Operate Foot Control					
						Environment					
						Inside					
						Outside					
						Heat					
						Cold					
						Dusty					
						Noisy					
						Other					

ADDITIONAL COMMENTS:

Employer Signature:	Employee Signature:
Employer Contact Title/Date:	Date:
<u>FOR PHYSICIAN TO COMPLETE:</u>	
Is this job appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Release: _____	
If not released to regular work at this time, please provide an "ANTICIPATED" DATE: _____	
Physician's Signature:	Date:

Oregon Military Department EMPLOYEE LEAVE REQUEST/RECORD

Please complete this form every time you use any paid or unpaid leave. If reason for leave includes one of the FMLA/OFLA qualifying reasons identified below, this form must be forwarded to AGP PERSONNEL immediately.

EMPLOYEE NAME: _____ SECTION: _____

TODAY'S DATE: _____

Have you worked for the State of Oregon/OMD for at least 180 days (6 months)? Yes ___ No ___

I request one day of leave or less: _____
Date Hours

I request more than one day: _____
Beginning Date Return Date

Total number of hours taken: _____

I request that my leave be charged to:

- Vacation Sick
- Unpaid Leave Personal Time (PB)
- Other _____

**IF FMLA/OFLA LEAVE, YOU MUST COMPLETE THIS SECTION.
OTHERWISE, YOU MAY PROCEED TO THE SIGNATURE LINE AT THE BOTTOM OF PAGE.**

(Note: Because it is OMD's responsibility to track leave and notify employees of their FMLA/OFLA status, we are required to obtain the information requested below. In some instances it may also be necessary for OMD to ask for additional information to determine whether the leave is FMLA/OFLA qualifying).

Please check one of the following:

- Your serious health condition (Medical certification may be required) (FMLA/OFLA)
- Family member with serious health condition (Medical certification may be required) (FMLA/OFLA)
- Child requiring home care (Non-Serious Health Condition) ("Sick Child" leave) (OFLA)
- Pregnancy (Includes prenatal care, childbirth, and recovery) (FMLA/OFLA)
- Care for a newborn child (FMLA/OFLA)
- Placement/adoption of child or adult dependent (FMLA/OFLA)
- Workers Compensation Claim

Do you have a spouse who works for State of Oregon/OMD who is requesting time off for the same purpose?
 Yes No (Restrictions may apply. OAR 839-009-0240. Contact AGP)

If you are requesting an altered or reduced work schedule for medical reasons, either for yourself or family members, please indicate your scheduling needs:

(Attach a separate sheet if necessary.)

EMPLOYEE SIGNATURE: _____

Confidentiality: Any disclosure of medical information will be kept in AGP's confidential medical file and will be used only to determine eligibility for FMLA/OFLA and to track leave.

Leave Approved Not Approved Supervisor's Signature: _____

Instructions for Completion of OMD Employee Leave Request/Record

- (1) This form is to be completed every time an employee uses paid or unpaid leave. In most instances this form will be completed prior to the leave being taken. When circumstances are such that the employee cannot complete the form in advance, he/she should do so on his/her first day back to work.
- (2) This form should be maintained in the individual departmental or supervisory file for record-keeping purposes, and to assist with the completion of the employee's timesheet or on-line time reporting. Current State retention schedule requirements indicate that "employee time records" including hours worked and leave hours should be retained for 4 years.
- (3) If the employee is not available to sign this leave request (i.e. employee is off work for medical reasons), and the supervisor believes that the reason for the employee's absence may be a qualifying reason under FMLA/OFLA, the supervisor should complete the form as completely as possible, and as soon as they are notified of the absence. The form should then be sent directly to OMD AGP for additional follow-up to determine whether FMLA/OFLA applies. Once an FMLA/OFLA packet is sent to the employee, a copy of the cover letter will be sent to the employee's supervisor.
- (4) As indicated on the form, any confidential medical information received will be kept in AGP's confidential medical files, and will be used only to determine eligibility for FMLA/OFLA and to track leave. Any accompanying confidential medical information should not be maintained in departmental or supervisory files. All confidential medical information should be forwarded to OMD's AGP. **If the employee's reason for leave is identified as an FMLA/OFLA qualifying reason, the original copy of this form should be forwarded immediately to AGP so that a complete FMLA/OFLA packet can be sent to the employee.**
- (5) Employees are responsible for notifying their supervisors 30 days prior to the requested start date of the leave if they have a condition or situation that could possibly qualify under either the Family and Medical Leave Act (FMLA) or the Oregon Family Leave Act (OFLA), and the need for leave is foreseeable. In any event, the employee must notify his/her supervisor as soon as practicable (normally within one or two business days). If an employee is incapacitated, a family member or other responsible party may submit the request for leave on behalf of the employee. Such notification is required whether or not the employee has paid leave to cover any of the necessary time off work.

Additional questions regarding leaves that may qualify under FMLA/OFLA should be directed to AGP at 503-584-3583.



OREGON MILITARY DEPARTMENT
 JOINT FORCE HEADQUARTERS, OREGON NATIONAL GUARD
 ADJUTANT GENERAL PERSONNEL
 1776 MILITIA WAY
 P.O. BOX 14350
 SALEM, OREGON 97309-5047

DATE:

TO: (Employee Name) _____
 (Date of Injury) _____
 (Regular Work Area) _____

FROM: (Name of Supervisor) _____

SUBJECT: Temporary Modified/Transitional–Duty Assignment

I am pleased to offer you a temporary modified/transitional-duty assignment in (area & location) _____ as of (date & time) _____ during your recovery. You will be receiving your regular salary of \$ _____ per month. SAIF Corporation may supplement your wages with workers' compensation benefits.

The tasks assigned are based on your physician's medically documented restrictions. You should not at any time exceed your medical restrictions and/or any hour limitations. If you feel you are being asked to do so, contact the Safety Manager at 503-584-3581 immediately.

This temporary modified/transitional-duty assignment will be reviewed after 30 consecutive calendar days from the date listed above. During this period, we expect you will recover from your injury. Before this assignment ends, your attending doctor will, hopefully, release you to your regular job without permanent restrictions.

However, if you are not released to your regular job within 30 days but you are progressing toward recovery and release to regular work, this temporary assignment may be extended for a limited time. If your doctor documents that you will be unable to return to your regular job because of permanent medical restrictions, we must consider other employment options for you. Therefore, it is important that you, your doctor and I remain in regular contact with regard to your progress toward recovery. In the event that you may not be able to return to your regular job, you should notify the Safety Manager at 503-584-3581 immediately. Other employment options or benefit opportunities can be explored.

This program is designed to enhance and speed your recovery. We look forward to your return to your regular assignment. If you have any questions, call me at _____ (Supervisor phone number) or the Safety Manager at 503-584-3581.

I have read and understand the above information.

 Employee Signature and Date

Attchmt: Release to Return to Work Form

Copy to: Employee & Original to Safety Manager