Injury Reporting & Workers’ Compensation

Trish Lijana
Workers’ Compensation Program Manager
346-2907 trish@uoregon.edu
TOP BODY PARTS INJURED

- Back, Lower: 35%
- Finger(s): 25%
- Knee: 20%
- Shoulder(s): 15%
- Wrist: 10%
- Ankle: 7%
- Head: 5%

% WC Claims 2014-2016 (data not all inclusive)
**TOP CAUSES OF INJURIES**

- **Strain/Sprain**: 90%
- **Slip/Trip/Fall**: 60%
- **Struck By**: 30%
- **Cut/Puncture**: 20%
- **Struck Stationary Object**: 10%
- **Burn**: 5%

% WC Claims 2014-2016 (data not all inclusive)
ACCIDENTS
whether Great...
or Small
REPORT THEM ALL !!!
WHY REPORT AN INJURY?

• Identifies potential hazard(s)
• Alerts UO to investigate
• Opportunity to correct hazard while minor
• Can prevent same injury from happening to someone else
• Reporting within 24 hours is imperative
• Protects injured employee
HOW TO REPORT AN INJURY

• Safety Incident/Accident Report (SIAR) form

• Supervisor completes SIAR with injured employee

• Opportunity to understand underlying factors that may have contributed to the injury

• Implement changes to prevent a reoccurrence

• Complete partial SIAR if employee is not available

• Sign & fax/email SIAR to Risk Management
UNIVERSITY OF OREGON
SAFETY INCIDENT or ACCIDENT REPORT (SIAR)

Office of Risk Management
1260 University of Oregon
1715 Franklin Blvd., Suite 2A
Phone: 541-346-8316
Fax: 541-346-7008
RiskManagement@uoregon.edu

Instructions: To be completed by employee with a supervisor/manager (unclassified) WITHIN 24 HOURS of when employee reports a work-related accident, incident or condition. Complete ALL sections, do not leave any blanks.

Department: Campus Operations
Date of Incident: 2/22/17
Date of Report: 2/22/17
Time of Incident: 2:30 pm, a.m. or p.m.

Employee Information:

Employee Name: LiJana, Trish
Employee ID#: 951-23-4567
Birth Date: 1/1/92
Employee Category:
- Regular, full-time
- Temporary UO
- Temporary Agency
- Regular, part-time
- Student Worker
- Volunteer
Position Title: Laborer
Working Days: M T W T F S S
Working Hours: 7:30am - 4pm

Injury Information:

Treatment:
- Received 1st aid
- Will be seeking medical treatment
- Received medical treatment
  (Workers’ Compensation Form 801 must also be completed)
- Hospital transport*
- Fatality*
- No treatment
- Other

Work Status:
- Left work early
- Missed work, dates:
- No missed work

Nature of Injury:
- Burn
- Inflammation/irritation
- Bruise
- Scratches/abrasions
- Cut
- Sprain/strain
- Other
- Headache

Body Part Affected:
- back of head
- Left
- Right
- Both

Cause of Injury:
- Burned by:
- Cut by:
- Contact with:
- Struck by:
- Fall/Slip/Trip
- Different level
- Same level
- Floor condition
- Weather condition
- Over object
- On sidewalk/path
- On stairs
- Sprain/Strain
- Lifting
- Bending/squatting
- Holding/carrying
- Pushing/pulling
- Reaching
- Repetitive motion
- Stairs
- Twisting/turning
- Walking
- Other

Was blood present? Yes No
If yes, was anyone else exposed to blood? Yes No
How was blood cleaned up?

*If fatality or hospital transport, call Office of Risk Management immediately at 541-346-8316.
**Any employee who was exposed to blood or other potentially infectious materials may require a medical consultation within 24 hours. Call Environmental Health & Safety 541-346-3192.
**Incident Details:**

<table>
<thead>
<tr>
<th>Specific Site of Incident (i.e. building, room, etc.)</th>
<th>SOUTH AGATE NEAR OREGON HALL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task/Activity at Time of Incident</strong></td>
<td>DRIVING CAR WITH LADDER TO CLEAN GUTTERS ON CAMPUS</td>
</tr>
</tbody>
</table>

**Describe Incident**

List the sequence of events; what happened and why.

- DRIVING CAR WITH LADDER IN BACK SEAT
- CAR STRUCK POT HOLE IN ROAD
- LADDER SHIFTED IN BACK SEAT
- LADDER STRUCK BACK OF MY HEAD

**Root Causes:**

Identify factors that may have contributed to or caused incident (check all that apply):

<table>
<thead>
<tr>
<th>Management</th>
<th>Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Safety procedures need to be reviewed</td>
<td>☐ Improper use</td>
</tr>
<tr>
<td>☐ Training needed</td>
<td>☐ Proper tool not available or not used</td>
</tr>
<tr>
<td>☐ Ergonomics or body mechanics</td>
<td>☐ PPE needs to be reviewed</td>
</tr>
</tbody>
</table>

**Environment**

- ☐ Building condition
- ☐ Chemicals
- ☐ Lighting
- ☐ Weather
- ☐ Caused by a 3rd party

**Other/Explain:**

- WAS USING PERSONAL VEHICLE
- LADDER WAS ALREADY AVAILABLE AT WORKSITE LOCATION

**Recommendations:**

**What can be done to prevent this incident from happening again?**

- ☐ Training
- ☐ Maintenance/repair
- ☐ Request assistance with task
- ☐ Other

**Explain:** PROVIDE TRAINING ON HOW TO REQUEST USE OF DEPARTMENT VEHICLE & HOW TO CHECK INVENTORY OF EQUIPMENT/TOOLS AVAILABLE AT DESTINATION BEFORE DEPARTING

**Who will follow up?** TRISH'S SUPERVISOR | Date to be completed:** TOMORROW

**Signatures:** By signing below, I certify that this information is true and correct to the best of my knowledge.

<table>
<thead>
<tr>
<th>Employee</th>
<th>Signature</th>
<th>Date</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRISH LIJANA</td>
<td></td>
<td>2/22/17</td>
<td>6-2907</td>
</tr>
<tr>
<td>HAILY GRIFFITH</td>
<td></td>
<td>2/22/17</td>
<td>6-2962</td>
</tr>
</tbody>
</table>

Return this form to Risk Management WITHIN 24 HOURS of notice of incident

FAX: 541-346-7008
# MEDICAL TRANSPORTATION OPTIONS

## REPORT ALL INJURIES

<table>
<thead>
<tr>
<th>INJURY</th>
<th>Non-Emergency</th>
<th>Urgent First Aid</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOUR RESPONSE</td>
<td>Self-Transport (walking or driving)</td>
<td>Call UOPD (541) 346-2919</td>
<td>Ambulance Call 911</td>
</tr>
<tr>
<td>MEDICAL CARE REQUIRED</td>
<td>Non-Emergency</td>
<td>On-Site First Aid (by UOPD or MedExpress) or Doctor Visit</td>
<td>Immediate Life Threatening</td>
</tr>
<tr>
<td>EXAMPLES</td>
<td>Bumps, bruises, minor strain/sprain. Students can treat at University Health Center.</td>
<td>Laceration that may need stitches, sprains/strains, severe bruises, insect bites, rashes, etc.</td>
<td>Severe bleeding, difficulty breathing, chest pain, broken bones, head injuries, etc.</td>
</tr>
<tr>
<td>NOTES</td>
<td>UO employee assumes risks when transporting an injured employee in personal vehicle.</td>
<td>UOPD officers are First Aid Certified and can arrange for MedExpress to treat injured employee on site.</td>
<td>Notify Risk Management of Transport IMMEDIATELY (541) 346-8316</td>
</tr>
</tbody>
</table>

**STEPS FOR ALL EMERGENCY LEVELS:**

1. Care for injured employee - provide 1st aid or call for medical evaluation as shown above
2. Fill out Safety Incident/Accident Report (SIAR) and email/fax to contacts on form within 24 hours
3. SIAR form and Workers' Compensation information can be found at: safety.uoregon.edu/injury-reporting-and-workers-compensation
4. For additional support, contact Risk Management: 541-346-8316
WHAT IS WORKERS’ COMPENSATION?

• Employers must carry insurance to cover occupational injuries

• UO’s Workers’ Compensation (WC) Insurer is State Accident Insurance Fund (SAIF)

• Employees can receive medical benefits and lost wages through a WC claim

• Waive pain and suffering compensation

• “No fault” insurance
HOW TO FILE A WC CLAIM

• Workplace injury occurs

• Employee has received medical treatment or intends to

• Employee has an option to file a WC claim

• Employee & supervisor complete an 801 form **within 24 hours**

• Employee signature on 801 form authorizes wc claim

• Fax completed 801 form to Risk Management

• Do not email 801 form if SS# is provided
# Report of Job Injury or Illness

## Workers' Compensation Claim

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.

<table>
<thead>
<tr>
<th>1. Date of injury or illness:</th>
<th>2. Date you left work:</th>
<th>3. Time you began work on day of injury:</th>
<th>a.m.</th>
<th>p.m.</th>
<th>4. Regularly scheduled days off:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Time of injury or illness:</th>
<th>6. Time you left work:</th>
<th>7. Shift on day of injury: (from)</th>
<th>a.m.</th>
<th>p.m.</th>
<th>(to)</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.m.</td>
<td>a.m.</td>
<td>p.m.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>p.m.</td>
<td>p.m.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. What is your illness or injury? Which part of the body? Which side?</th>
<th>9. Check here if you have more than one job:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Sprained right foot</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td></td>
</tr>
</tbody>
</table>

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)

---

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.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spanish [ ] Other [ ] (please specify): [ ]</td>
<td></td>
<td>M [ ] F [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. Your mailing address, city, state and zip:</th>
<th>16. Home phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20. Names of witnesses:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21. Name and phone number of health insurance company:</th>
<th>22. Name and address of health care provider who treated you for the injury or illness you are now reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23. Have you previously injured this body part?:</th>
<th>24. Were you hospitalized overnight?:</th>
<th>25. Were you treated in the emergency room?:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes [x] No</td>
<td>[ ] Yes [x] No</td>
<td>[ ] Yes [x] No</td>
</tr>
</tbody>
</table>

| 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(f)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. |

<table>
<thead>
<tr>
<th>27. Worker signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28. Completed by (please print):</th>
<th>29. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Employer Section of 801 Form

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.

<table>
<thead>
<tr>
<th>Employer legal business name:</th>
<th>University of Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. Phone:</td>
<td>(541) 346-2907</td>
</tr>
<tr>
<td>32. FEIN:</td>
<td>464727800</td>
</tr>
<tr>
<td>35. Address of principal place of business:</td>
<td>1715 Franklin Blvd, Suite 2A, Eugene OR 97403</td>
</tr>
<tr>
<td>37. Street address from which worker is/was supervised:</td>
<td>ZIP:</td>
</tr>
<tr>
<td>39. Address where event occurred:</td>
<td></td>
</tr>
</tbody>
</table>

#### Education

<table>
<thead>
<tr>
<th>41. Class code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>45. Date employer knew of claim:</th>
<th>46. Worker’s wage per hour $</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>49. Return-to-work status:</th>
<th>Not returned</th>
<th>Regular Date:</th>
<th>Modified Date:</th>
</tr>
</thead>
</table>

| 51. Employer signature: |

**OSHA requirements:** On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.
Occupational Medicine Clinics

Options if employee’s physician is not available:

• **Cascade Health Solutions**
  Located near Costco off Coburg Road in northeast Eugene

• **Urgent Care**
  Three locations: University District, Coburg/Beltline, Thurston

• **PeaceHealth Urgent Care**
  Two locations: Gateway Street and Game Farm Road in Springfield, and West 11th Avenue in Eugene

• **University Health Center**
  On campus at 13th Avenue and Agate Street for student employees
WORK RELEASE/STATUS REPORT

• Resume regular duties

• Restrictions; may require modified tasks or transitional work

• Not released to any work

• Fax/email work releases to Risk Management
RETURN TO TRANSITIONAL WORK

• As soon as possible after injury

Benefits:
  - Improves healing process, faster recovery
  - Reduces retraining costs
  - Loss of productivity

• If off work over 6 months
  50% chance of returning to work

• If off work over 1 year
  90% chance will never return to work

• Reduced hours is an option

• Employer-At-Injury Program (EAIP)
What is the cost of an injury?
# Average Medical & Lost Wage Costs per Claim

<table>
<thead>
<tr>
<th>Year</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY11</td>
<td>$7,278</td>
</tr>
<tr>
<td>FY12</td>
<td>$4,783</td>
</tr>
<tr>
<td>FY13</td>
<td>$4,276</td>
</tr>
<tr>
<td>FY14</td>
<td>$4,132</td>
</tr>
<tr>
<td>FY15</td>
<td>$3,937</td>
</tr>
<tr>
<td>FY16</td>
<td>$4,994</td>
</tr>
</tbody>
</table>

The graph above illustrates the average medical and lost wage costs per claim from FY11 to FY17. The costs are shown in dollars, with FY11 having the highest cost at $7,278, and FY15 having the lowest at $3,937. The costs decrease gradually from FY11 to FY15, with a slight increase in FY16 to $4,994.
Plus Uninsured Costs

- Down time
- Decreased morale
- Unsatisfied customers
- Expenses to retrain
- Damaged property or equipment
What about the injured employee?

**People costs**

- Pain and suffering
- Physical limitations
- Permanent impairment
- Reduced earning ability
- Family relations
- Psychological factors
How to Access Injury Forms

U'O'REGON.EDU/

Search

Injury Reporting and Workers' Compensation | Safety and Risk...
Employees are covered by workers' compensation insurance when they suffer a compensable injury/disease in the course and scope of employment.

Preventing Injuries
Put the two together and you have the potential for severe injury. Direct physical trauma can result from falling, the unpredictable nature of eroding rock, and oppos.oregon.edu/climbing/topics/injuries.html

Effects of Illness and Injury on Foraging Among the Yora and Shiwiar
Effects of Illness and Injury on Foraging Among the Yora and Shiwiar. Pathology Risk as ... mechanisms dedicated to the problems of injury and illness. darkwing.oregon.edu/.../Sugiyama%20Effects%20of%20Injury%20and%20Illness%20in%20...
Injury Reporting and WC Contacts

• Risk Management
  Trish Lijana, Workers' Compensation, 541-346-2907, trish@uoregon.edu
  Office of Risk Management, 541-346-8316, riskmanagement@uoregon.edu

Safety Incident or Accident Report (SIAR)

Workers' Compensation Claim Form (ENGLISH 801) (SPANISH 801)

Employee Status Report (ESR)
The employee takes this form to doctor appointments for the physician to complete every 30 days.

Occupational Medicine Clinics
These locations are some of the available options for treatment of an occupational injury.

Options for Medical Transport
Download and use this chart as a guide when determining what level of medical treatment is required following a workplace injury.
Injury - Needs Medical Treatment

WE JUST ENTERED ROOM AND OBSERVED AN INJURY
TAKE-AWAYS

• Report all injuries, regardless of severity

• Refer to Medical Transport Chart when injuries occur

• Complete Safety Incident/Accident Report (SIAR) form within 24 hours

• If medical treatment is required, determine if employee will file a WC claim
  • If yes, complete 801 form

• Fax all forms to Risk Management
QUESTIONS?