"MEDICAL ATTENTION REQUIRED" PACKET INSTRUCTIONS

If you require immediate medical attention notify your supervisor immediately (if the injury is life threatening call 911 immediately). You must complete the claim reporting process as soon as medically possible or within 24 hours of the incident. The following material can be found in the Employee Injury/Incident "Medical Attention Required" packet.

- Incident Report (Wasco County)
- Accident Report Form 801 (SAIF Corporation)
- Authorization to Release Information (SAIF Corporation)
- Notice to Doctor/Return to Work (Wasco County)
- General Safety Policy (Wasco County)
- On-The-Job Injury or Illness Policy/Procedures (Wasco County)

Instructions:

Incident Report: Fill out the entire Employee Section and please be as specific as you can. Sign and date the form at the bottom of the page. Place the completed form in the packet and check the box indicating you have reviewed and completed the form.

Accident Report Form 801: Complete lines1-21 in the WORKER section, page 2 of 2 of the 801 form. Place the completed form in the packet and check the box indicating you have reviewed and completed the form.

Notice to Doctor/Return to Work: You must have your attending physician complete and sign this form before you can return to work. You must either take this form with you on your initial visit or take it to your attending physician within 24 hours of the incident (if medically possible). Check the box on the packet to indicate you understand your responsibilities regarding this form.

Authorization to Release Information: Review and complete the SAIF Corporation Authorization to Obtain/Release Information Form. Please make sure that you sign the form in each section. Place the completed form in the packet and check the box indicating you have reviewed and completed the form.

General Safety Policy: Read the General Safety Policy. Sign and date the "Employee Acknowledgement Form" on the last page of the policy indicating that you have read and understand the policy. Place the signed "Employee Acknowledgement Form" page in the packet and check the box indicating you have reviewed and understand the policy. You may keep the copy of the policy for your personal records.

On-The-Job Injury or Illness Policy/Procedures: Read the On-The-Job Injury or Illness Policy/Procedures. Sign and date the "Employee Acknowledgement Form" indicating that you have read and understand the policy. Place the signed "Employee Acknowledgement Form" page in the packet and check the box indicating you have reviewed and understand the policy. You may keep the copy of the policy for your personal records.

PLEASE RETURN THE COMPLETED PACKET TO HUMAN RESOURCES

WASCO COUNTY

INCIDENT/ACCIDENT/ILLNESS REPORT

EMPLOYEE SECTION: WAS MEDICAL ATTENTION NEEDED? YES ☐ NO ☐

NAME_____ JOB TITLE_____

TODAY'S DATE_____ DEPARTMENT _____

LOCATION OF ACCIDENT_____ SUPERVISOR_____

DATE OF INJURY_____TIME OF INJURY_____ DATE ACCIDENT REPORTED_____TIME REPORTED_

ACCIDENT REPORTED TO_____ HOW WAS ACCIDENT REPORTED? VERBAL ☐ WRITTEN ☐

DATE LEFT WORK_____TIME LEFT WORK_ NAME(S) OF WITNESSES_____

PROVIDE SPECIFIC DETAILS OF HOW INJURY OCCURRED: (attach additional info if necessary):_____

_____

_____

_____

PART(s) OF BODY AFFECTED

HEAD/NECK	LEFT SIDE	RIGHT SIDE
☐ NECK	☐	☐
☐ EARS	☐	☐
☐ EYES	☐	☐
☐ MOUTH	☐	☐
☐ TEETH	☐	☐
☐ FACE	☐	☐

UPPER EXTREMITIES	LEFT SIDE	RIGHT SIDE
☐ SHOULDER	☐	☐
☐ UPPER ARM	☐	☐
☐ ELBOW/FOREARM	☐	☐
☐ WRIST	☐	☐
☐ HAND	☐	☐
☐ FINGERS	☐	☐

LOWER EXTREMITIES	LEFT SIDE	RIGHT SIDE
☐ THIGH	☐	☐
☐ LOWER LEG	☐	☐
☐ KNEE	☐	☐
☐ ANKLE	☐	☐
☐ FOOT/TOES	☐	☐
☐ TOES	☐	☐

TRUNK	LEFT SIDE	RIGHT SIDE
☐ LOWER BACK	☐	☐
☐ UPPER BACK	☐	☐
☐ CHEST	☐	☐
☐ ABDOMEN	☐	☐
☐ HIP	☐	☐
☐ GROIN	☐	☐

NATURE OF INJURY

☐ SPRAIN/STRAIN	☐ EXPOSURE TO DISEASE
☐ CUT/PUNCTURE	☐ FOREIGN BODY
☐ SCRAPE	☐ BURN
☐ CRUSH/BRUISE	☐ ELECTRIC SHOCK
☐ SKIN RASH	☐ PAIN
☐ AMPUTATION	☐ JAMMED APPENDAGE
☐ OTHER_____	

WORK BEHAVIOR

- ☐ MOVING WORK MATERIALS
- ☐ DRIVING VEHICLE
- ☐ LIFTING OR CARRYING EQUIPMENT, TOOLS, ETC.
- ☐ PUSHING/PULLING EQUIPMENT, MATERIAL OR MACHINERY
- ☐ WORKING ALONE
- ☐ WORKING WITH OTHERS-NAMES:_____

SAFETY EQUIPMENT IN USE

- ☐ PROPER FOOTWEAR
- ☐ SAFETY GLASSES/GOOGLES/FACE SHIELD
- ☐ GLOVES
- ☐ HEARING PROTECTION
- ☐ SEAT BEALT/SAFETY HARNESS
- ☐ RESPIRATORS

CONTRIBUTING CONDITIONS

- ☐ DEFECTIVE MACHINERY (*SAVE BROKEN PARTS & PIECES*)
- ☐ UNSAFE CLOTHING
- ☐ FAULTY FLOOR OR SURFACE
- ☐ POOR HOUSEKEEPING
- ☐ TOOL OR EQUIPMENT BROKEN (*SAVE BROKEN PARTS & PIECES*)
- ☐ SPECIAL CLOTHING

HAVE INDICATED BODY PARTS BEEN INJURED PREVIOUSLY OR IS THERE ANY PRE-EXISTING CONDITION THAT WILL AFFECT THIS INJURY: YES ☐ NO ☐ IF YES, PLEASE EXPLAIN: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

SUPERVISOR SECTION: **FORM 801 FILLED OUT? YES ☐ NO ☐**

EMPLOYEE WORK BEHAVIOR

- ☐ IMPROPERLY USING TOOLS OR EQUIPMENT
- ☐ WORKING BEYOND SKILL LEVEL
- ☐ INATTENTION TO SURROUNDINGS
- ☐ FAILURE TO GET ASSISTANCE
- ☐ IMPROPER LIFTING TECHNIQUE
- ☐ FAILURE TO FOLLOW WORK RULE(S)
- ☐ HORSEPLAY
- ☐ ASSAULT BY / ON WORKER

SAFETY EQUIPMENT

- ☐ ADEQUATE
- ☐ INADEQUATE
- ☐ IMPROPERLY USED
- ☐ NOT AVAILABLE
- ☐ NOT USED
- ☐ DAMAGED (*SAVED BROKEN PARTS/PIECES*)

SAFETY RULES

- ☐ ADEQUATE FOR SITUATION
- ☐ INADEQUATE FOR SITUATION
- ☐ IMPROPERLY FOLLOWED
- ☐ NOT FOLLOWED
- ☐ NOT ENFORCED
- ☐ NOT KNOWN BY WORKER

DESCRIBE WHAT THE WORKER WAS DOING PRIOR TO AND AT THE TIME OF THE ACCIDENT (SPECIFIC SEQUENCE OF EVENTS):

_____

_____

_____

_____

_____

_____

DESCRIBE FIRST AID GIVEN (WHEN AND BY WHOM):_____

_____

IS THERE ANY REASON TO QUESTION THIS IS AS JOB RELATED? YES ☐ NO ☐ IF YES, LIST SPECIFIC REASONS:_____

_____

_____

WHAT DO **YOU** THINK CAN BE DONE TO PREVENT FURTHER INCIDENTS OF THIS NATURE?_____

_____

_____

NAME OF WITNESS(ES) TO INCIDENT_____

ADDRESS (IF NOT EMPLOYEE)_____ PHONE NUMBER (IF NOT EMPLOYEE)_____

WITNESS(ES) SIGNATURE(S)_____ DATE_____

CORRECTIVE ACTION NEEDED:

- ☐ IMPROVE JOB DESIGN
- ☐ IMPROVE HOUSEKEEPING
- ☐ ENFORCE RULES/PROCEDURES
- ☐ REPAIR OR REPLACE EQUIPMENT
- ☐ MORE DIRECT SUPERVISION
- ☐ SAFETY EQUIPMENT
- ☐ TRAINING
- ☐ ESTABLISH NEW RULES/PROCEDURES
- ☐ JOB SAFETY ANALYSIS
- ☐ DISCIPLINE (DESCRIBE):_____

SUPERVISOR'S SIGNATURE: _____ **DATE:**_____

SAFETY COMMITTEE REVIEW DATE: YES ☐ NO ☐ **DATE:**_____

saif

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, 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:
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.		Emp
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: ☐	Ins
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)				Occ
				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(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. **I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.**

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 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	

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

51. Employer signature:	52. Name and title (please print):	53. Date:

801
X801 1/17

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.

A guide for workers recently hurt on the job

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

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

440-3283 (01/17/DCBS/WCD/WEB) for distribution with X801 SAIF 1/17

SAIF Corporation
400 High St. S.E.
Salem, OR 97312-1000
(503) 373-8000

saif Work. Life. Oregon.

Authorization to Release Information

Name: _____
Claim Number: _____
S.S. Number: _____
Date of Birth: _____

I, _____, do hereby authorize
(Name of Claimant)
_____ to disclose upon request of SAIF
(Hospital, Physician, Clinic or Insurance Co.)

Corporation or its representatives, _____, any and all information, including, but not limited to, written reports of hospital or medical records of history, x-rays, consultations, examinations, prescriptions or treatment, relating to any illness or injury which I might have incurred or suffered. This information is being disclosed to SAIF Corporation or the above-named representative to assist in determining the extent and nature of my eligibility for Workers' Compensation benefits. I am aware that this consent is subject to revocation in writing at any time by me, except to the extent that action has been taken in reliance thereon prior to that notice of revocation. In any event, this consent will expire eight (8) years from the date it is signed. I recognize that the information disclosed may contact information that is protected by Federal and State Law, and I specifically consent to disclose of such information relating to mental or psychiatric conditions or treatment, Human Immunodeficiency Virus (HIV/AIDS) testing or treatment and alcohol and/or drug abuse. A photo-static copy of this authorization shall be considered as effective and valid as the original.

Dated: _____ _____
(Claimant)
_____
(Street Address)
_____
(City) (State)

Authorization to Release Information to Workers' Compensation Regulatory Agencies

I hereby authorize SAIF Corporation to release copies of all the medical information gathered by it in relation to my claim for compensation benefits to the Department of Insurance and Finance, Workers' Compensation Division and/or Workers' Compensation Board and/or U.S. Department of Labor for the purpose of assisting in determining the nature and extent of my entitlement to Workers' Compensation benefits.

Dated: _____ Claimant:_____

HUMAN RESOURCES

511 Washington St, Ste 206 • The Dalles, OR 97058
p: [541] 506-2774 • f: [541] 506-2771 • www.co.wasco.or.us

Pioneering pathways to prosperity.

NOTICE TO DOCTOR

(To be presented by injured worker when reporting for treatment and returned to employer)

_____ has reported that he/she was injured on _____(date).

Date: _____ Employer's signature:_____

RETURN TO WORK

(To be completed by doctor after examining employee)

This worker's employer will make every effort to make modified work available to this employee in the belief that it will result in quicker recovery and less disability.

Medical Office or Clinic Name: _____

Treatment Date: _____ Time arrived: _____ Time left: _____

Is Employee able to return to regular work duties? Yes ☐ No ☐

Projected date of return to regular or light-duty work: _____

PLEASE IDENTIFY THE PHYSICAL RESTRICTIONS:

Lifting:
- ☐ 10 lbs maximum, 5 lbs frequently
- ☐ 20 lbs maximum, 10 lbs frequently
- ☐ 50 lbs maximum, 25 lbs frequently
- ☐ over 50 lbs maximum, up to 50 lbs frequently

Endurance (total hours, with breaks, in 8 hour day):

Sit:	0	1	2	3	4	5	6	7	8
Stand:	0	1	2	3	4	5	6	7	8
Walk:	0	1	2	3	4	5	6	7	8

How many hours can patient work per day?_____

ACTIVITY	NONE	OCCASIONALLY (up to 33% of time)	FREQUENTLY (34%-66% of time)
Stoop/Twist/Bend	☐	☐	☐
Squat/Crawl/Kneel	☐	☐	☐
Climb	☐	☐	☐
Reach above shoulder (L)(R) Both	☐	☐	☐
Push/Pull (L) (R) (Both)	☐	☐	☐

EXTREMITIES:
☐ No use of hand/arm ☐R ☐L
Can use foot pedals? ☐ yes ☐ no

COMMENTS: _____

_____

_____

Next Appointment: _____ or Patient referred:_____

_____Date:_____

Physician's Signature

HUMAN RESOURCES

511 Washington St, Ste 206 • The Dalles, OR 97058
p: [541] 506-2774 • **f:** [541] 506-2771 • www.co.wasco.or.us

Pioneering pathways to prosperity.

Wasco County Policy Acknowledgement Form

I, the undersigned employee of Wasco County, hereby certify that I have read and understand the contents of the Wasco County General Safety Policy as well as the Wasco County On-the-Job Injury/Illness Policy and Procedures.

Name (Please Print): _____

Signature: _____

Date: _____

Wasco County
General Safety Policy & Rules

General Safety Policy: Wasco County is committed to providing a safe and healthy workplace for all employees. The County complies with all applicable requirements issued by the federal Occupational Health and Safety Administration.

The objective of the safety and health program is to reduce or eliminate disabling injuries and illnesses. It is the policy of the County to exercise all precautions necessary to protect employees from all accidents. The County firmly believes that all accidents are preventable.

The responsibility for the success of the safety and health program is shared by management and all employees working for the County. Enforcement of safety rules will be vigorous and equitable, reinforcing the intent to provide workplace safety. Supervisors are required to take quick, consistent action to change unsafe behavior. It is the responsibility of all employees to cooperate in making the safety program work, including compliance with all rules and regulations.

Safety Rules. Employees are required to observe all safety rules. Without limitation, but by way of illustration, the safety rules are:

- All County employees will observe County safety and health rules and apply the principles of accident prevention in their day-to-day duties.
- No employee shall knowingly violate a County safety rule or State Safety and Health Regulation.
- The use of intoxicating liquor or illegal drugs on the job is strictly prohibited. Anyone whose ability to work safely is impaired by alcohol, drugs or medication will not be allowed on the job.
- Each employee is responsible for their own safety and the safety of other employees. Unsafe working conditions shall be corrected or immediately reported to a supervisor.
- Employees will observe all lock-out/tag out procedures on any moving machine or tool before making changes, repairs, or while cleaning.
- No employee shall work alone when entering confined spaces or hazardous locations such as basins or manholes. Entry permits are required to be completed and followed prior to confined space entry.
- Employees must report unsafe or hazardous conditions (unsafe equipment, floors, material, etc.) and unsafe acts to their immediate supervisor or safety committee representative promptly.
- Employees must use personal protective equipment such as steel toe shoes, safety vests, safety glasses, hard hats, gait belts, back supports, etc. where required.

- Employees will not wear frayed, torn or loose clothing, jewelry, or long unrestrained hair near moving machinery or other sources of entanglement.

- Employees must keep working areas clear of slipping/tripping hazards.

- Employees will refrain from fighting, horseplay, or distracting other workers.

- Employees must report all job-related injuries or illnesses to their supervisors within 24 hours.

- Employees must assist supervisors in their investigation of any accident of which they have knowledge.

- Employees must practice safe operating procedures for all equipment.

- Employees will not operate, modify, adjust or use equipment in an unauthorized manner. Make sure all guards and other protective devices are in their proper places prior to operating equipment.

- Employees will only operate machines, tools, power trucks or County equipment that they are authorized to operate. Supervisors will provide proper equipment safety training for each employee as necessary. If for any reason an employee is asked to operate equipment they are not authorized to operate they must immediately report it to their supervisor.

- Employees will attend all required training or orientation to increase safety awareness

- Employees are required to know the location of fire/safety exits and evacuation procedures.

- Employees must observe all hazard warning and no smoking signs.

- Employees are strictly forbidden to be riders on tractors or any other mobile equipment, except for equipment designed to permit passengers.

- Employees are prohibited from using defective equipment, tools or machinery. All defective equipment, tools or machinery must be reported to a supervisor immediately. Examples: handles on tools that have sharp edges, splinters, or cracks; heads on shock tools such as hammers, sledges, and cold chisels that have mushroomed or cracked; cutting edges of tools that have dulled edges; electrical equipment with exposed wires, etc.

- Employees will follow proper lifting procedures at all times.

Failure to observe safety rules may result in disciplinary action, up to and including, termination.

Wasco County On-the-Job Injury or Illness Procedure Policy

Wasco County is committed to providing employees with a safe work environment and encouraging safe work habits. It is the objective of Wasco County to return injured workers to employment at the earliest date possible after an injury.

EMPLOYEE RESPONSIBILITIES

Reporting Requirements (no medical attention required)

Employees are encouraged to report any job-related injury, illness or property damage to their immediate supervisor within 24 hours of an incident.

Employees must provide their immediate supervisor information on how the injury happened by completing an on-the-job accident packet.

Reporting Requirements (medical attention required)

Employees are encouraged to report any job related injury, illness or property damage to their immediate supervisor within 24 hours of an incident and promptly complete an employee Claim Form (Form 801) and return it to the Human Resources office.
Employees are encouraged to seek treatment the same date as the injury.

Failure to timely follow these steps may negatively affect your ability to receive benefits.

If possible, before seeking medical treatment, the employee must obtain an on-the-job accident packet from their supervisor. This packet contains forms that must be presented to their attending physician for completion at the first visit. The completed forms must be returned to the immediate supervisor within 24 hours of the injury, or as soon as medically possible following treatment.

Full Medical Release

Employees treated within their scheduled work shift and released to work will report immediately to their supervisor with a full medical release from their attending physician. If released after the shift, the employee will contact their immediate supervisor at the beginning of their next scheduled shift. In all cases, employees are required to return all required documentation to their immediate supervisor upon return to work or within 24 hours of the injury.

Failure to report to work or contact an immediate supervisor after treatment of injury will result in disciplinary action up to and including termination.

Modified Work Release

Employees released to modified work will report immediately to their supervisor with all required documentation from the attending physician outlining their work limitations. If released after the shift, the employee will contact their immediate supervisor at the beginning of their next scheduled shift. In all cases, employees are required to return all required documentation to their immediate supervisor upon return to work, or within 24 hours.

Failure to report to work or contact an immediate supervisor after treatment of injury will result in disciplinary action up to and including termination.

Employees on modified work release must work within the physical limitations outlined by their treating physician. Failure to do so, or a failure to work safely, will result in disciplinary action up to and including termination.

Employees on modified work release must report in after every doctors' appointment in person. Failure to do so will result in disciplinary action up to and including termination and could affect their reemployment rights.

Employees must notify their immediate supervisor within 24 hours of any changes in their health status or receipt of an updated doctor's release for assessment of work restrictions.

Assignment of Modified Work

Wasco County retains the right to determine whether a modified work assignment can be provided which will be consistent with the treating physician's work restrictions and the needs of the department.

All work will be within the limitations set by the treating physician.

Reasonable effort will be made to accommodate the needs of the employee by modifying his/her present work setting, however, work availability may make it necessary to transfer employees within the department. Such transfers are solely at the option of the employer.

Employees may be required to move from one modified duty assignment to another if their health status changes or they complete an assignment prior to recovery.

Refusal of a physician approved modified job, by either verbal refusal, written refusal or refusal to report to work, will result in a reduction or termination of total or partial wage

replacement (ORS 656) and may result in loss of reinstatement rights and future vocational eligibility. Nothing in this paragraph should be interpreted to interfere with any rights of a worker under state or federal law, including, but not limited to the Family Medical Leave Act or the Americans with Disabilities Act.

Duration/Type of Modified Duty Assignment

Wasco County retains the right to determine duration of modified assignments and may alter or end the assignment without prior notice. Continuation of temporary modified work assignments for injured employees will be reviewed regularly.

The employee's recovery progress will be monitored to assess when and how often duties may be changed. All major changes in the work assignment will be made after receiving concurrence from the treating physician.

If an employee has a permanent disability, which restricts their ability to return to regular work, the modified job program may end.

Wasco County will determine whether a continuing modified position exists and whether the employee will be offered the modified job or another position as their new regular assignment.

Wasco County will determine whether the employee's physical restrictions require substantial modification of the employee's job duties and/or work environment and whether such modifications are possible (or are an undue hardship).

To the extent possible Wasco County will consider work site modification to allow the employee to continue employment.

Wage Information for Modified Work

Pay will be at the going rate of pay for the position at the time of injury.

If the modified position pays less than the employee's wage at injury, the County Worker's Comp carrier will pay the difference at the appropriate compensation rate.

Scheduling

Wasco County retains the right to change regular days off and work hours while the worker is in a modified position.

Injured employees working in modified positions are encouraged to schedule therapy and

doctor appointments around their work schedules to avoid loss of earning power. (Worker's Comp only pays wages for appointments requiring the worker to be gone from work four (4) or more hours.)

If this cannot be arranged, appointments should be scheduled at the end of the shift. Advance notification ofat least 48 hours is required.

Progress Evaluation

The employee's eligibility for modified work will be reviewed at regular intervals. The employee may be asked to obtain a current medical evaluation at that time, if no current medical information is available, to determine medical stability or the appropriateness of return to regular work. The County will then determine if modified work will continue to be made available.

Time worked in a modified position will be considered as time worked in determining seniority.

Employees Unable to Return to Work

If a worker is unable to participate in a modified job or no modified job exists, they will report in at least once every seven (7) days. The supervisor or their designee will contact the injured worker and agree upon a "regular" time and day of the week to maintain regular contact.

In all cases, it is the responsibility of the employee to contact their immediate supervisor at least once every seven (7) days. Disciplinary action, up to and including termination will be taken for employees who fail to report weekly.

All changes in an employee's health status must be presented to their immediate supervisor within 24 hours upon receipt of any updated doctor's release.

All employees must verify with their immediate supervisor their current address and phone number. Any changes must be reported promptly.

Failure to provide changes in medical condition, address or phone number could lead to disciplinary action, up to and including termination.

This on-the-job injury/illness policy will take effect immediately and may from time to time be revised. All revisions, as recommended and adopted by The *Wasco County Court, shall be made part of this policy as if said revisions were fully written hereunder.*

On-the-Job Injury or
Illness Procedure Policy
Adopted: 01/28/04
Revised: 06/21/2017

Nothing in this policy should be interpreted to interfere with any rights of a worker under state or federal law, including, but not limited to the Family Medical Leave Act, the American with Disabilities Act, and ORS 659A.043-.049 (reinstatement and reemployment).

"Failure to comply with any provision of this policy will result in disciplinary action up to and including termination and could affect reemployment rights."

APPROVED this 21st day of June, 2017.

WASCO COUNTY
BOARD OF COMMISSIONERS

Rod Runyon, Commission Chair

Steven D. Kramer, Commission Vice-Chair

Scott C. Hege, County Commissioner

APPROVED AS TO FORM:

Kristen Campbell
Wasco County Counsel