DEPARTMENT OF CONSUMER & BUSINESS SERVICES — Workers' Compensation Division

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL: WCD employer no.: ____ Policy no.: ____

Note to Provider: **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

Dept. Use: Ins. no. | Occ. | Nature | Part | Event | Source | Assoc. object

Worker or provider

Worker's legal name, street address, and mailing address:
Phone:

Language preference:
Male/female ☐ ☐
Social Security no. (see Form 3283):
Claim no. (if known):
Date/time of original injury:
Date of birth:
Occupation:
Last date worked:

Employer at time of original injury — name and street address:
Phone:

Health insurance company name and phone:
Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐ Yes ☐ No If yes, when: ____

Check here if you have more than one job. ☐
Describe accident:

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Condition: ____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: ____

☐ **Report of aggravation of original injury (actual worsening of underlying condition)**

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X ____ ***Worker's signature*** ____ ***Date***

Provider

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes, including diagnostic codes. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. **Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

☐ **Progress report** ***OR*** ☐ **Closing report** (See instructions in Bulletin 239.)
☐ **Palliative care request** – Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

a
Date/time of first treatment: | Last date treated: | Was worker hospitalized as an inpatient? ☐ Yes ☐ No — If yes, name hospital:
Next appointment date: | Est. length of further treatment: | Current diagnosis per ICD-9-CM codes:

b
Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown
Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

Work ability status:
☐ Regular work authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c
Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

X ____ ***Provider's signature*** ____ ***Date***

—Original and one copy to insurer
—Retain copy for your records
—Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

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