EMPLOYEE INJURY REPORT

INSTRUCTIONS: When a work-related injury occurs, an OSU employee is required to report the injury to his/her supervisor, and must complete the first section of the Employee Injury Report at the time of the injury. The supervisor is required to investigate any work-related injury and complete the second section of the Employee Injury Report at that time of the injury. The supervisor **should** accompany the employee for medical treatment at the designated medical facility (On the **Stillwater campus:** University Health Services during office hours or AMC Urgent Care after hours. **Tulsa/CHS Campus:** Health Care Clinic during office hours or OSU Medical Center after hours. **OKC Campus:** McBride's during office hours or McBride's hospital/nearest E.R. after hours. **OSU-IT Campus:** Once Source Occupational or Concentra Urgent Care**).**

Environmental Health Services or the branch campus safety office is to be notified of the accident by telephone.

<table>
<tr><td colspan="5">TO BE COMPLETED BY EMPLOYEE. **All fields must be completed**
(Please Print Legibly)</td></tr>
<tr><td>Name as on Social Security Card:
Last: First: MI:</td><td>CWID:</td><td>Sex:</td><td>Phone Number
Home: ( )
Work: ( )</td><td>Date of Birth:</td></tr>
<tr><td colspan="5">Home Mailing Address:
Street: City: State: Zip:</td></tr>
<tr><td colspan="2">Dept/Unit Name:</td><td colspan="3">Job Title:</td></tr>
<tr><td colspan="2">Injury Date: / /</td><td colspan="3">Time: □ AM □ PM</td></tr>
<tr><td colspan="5">Location of Injury: Room #: Building:</td></tr>
<tr><td colspan="2">Body Part Injured:
Finger_____Hand_____(Right/Left) Arm__Leg
_____(Right/Left) Torso_____Head_____

Other: _____</td><td colspan="3">Witness Name(s):</td></tr>
<tr><td colspan="5">Was injury reported on date it occurred: □ YES □ NO If NO, please explain:

To Whom Reported:

Date/Time Reported:

Did you seek medical attention before reporting: □ YES □ NO If YES, provide Dr. and explanation:

Dr. Name: Address: Phone:</td></tr>
<tr><td colspan="5">Describe how and what happened to cause injury:

Did Dr. require NO WORK for more than 3 days? □ YES □ NO
Has body part been injured before? □ YES □ NO
If yes, provide date of injury, Dr Name and treatment details:</td></tr>
<tr><td colspan="2">Supervisor's Name:</td><td>Supervisor's Phone:</td><td colspan="2">Was Supervisor notified: □YES □NO
If NO, explain:</td></tr>
<tr><td colspan="5">Employee Signature: Date Completed:</td></tr>
</table>

EMPLOYEE INJURY REPORT

TO BE COMPLETED BY SUPERVISOR (Please Print Legibly)		
Supervisor Name: Supervisor Phone:	Employee Name: Employee CWID:	Injured on employer's premises? □ YES □ NO Were others injured in this incident? □ YES □ NO

Is the injury questionable? □YES □NO If YES, please explain:

How could this injury have been prevented? (Note: "Be more careful" is not adequate. Please survey the scene of the accident and identify if something could have been done to prevent the accident such as a spill, faulty equipment, etc…)

RE: Sharps—if non-safety sharps device used, what other mechanism (administrative or work practice) may have prevented this injury?

Type of Event	**Contributing Condition**	**Contributing Behavior**
□Struck by _____ □ Caught in/under/between □ Overexertion □ Patient handling □ Material handling □ Fall/slip/trip □ Chemical or other exposure □ Body fluid splash □ Needle stick or sharps injury □ Other_____	□ Equipment defect or failure □PPE (personal protective equipment) unavailable □ Work area set-up/arrangement □ Floor/work surfaces □ Ventilation □ Lighting □ Disassembling equipment □ Safety device not activated (needle/sharp) □ Lack of Training □ Other_____	□ Inattention to task □ Rushing or hurried □ Failure to get assistance □ Not using assistive device (lift equipment) □ Procedure not followed □ Unbalanced/poor position or motion □ Bypassing safety device □ Failure to wear PPE □ Lack of experience by other person(s) □ Other

Action Taken to Prevent Reoccurrence: (Check)

□ Scheduled safety training
□ Developed/revised safety procedure
□ Ordered PPE
□ Took equipment out of service for repair/replacement
□ Reviewed policy/procedure
□ Ordered or posted hazard/warning signs
□ Reported equipment/condition to _
□ Counseled Employee _
□ Corrective Action _
□ Other_____

For Needle Stick/Sharps Injury: (Check) □Patient Room □ER □OR □ICU □Lab □Other: _

1. Exposed Substance: □Human blood □Non-human blood □Blood fluid
   Did employee bleed? □YES □NO Was visible blood on device? YES NO
2. When did incident occur? □During use □Between steps □After us but before disposal
   □During disposal □Sharp left in wrong place
3. Procedure was: □Blood draw □Injection □Start IV □IV flush □Cutting □Suturing □Other
4. Sharp product type/brand/mode_____Was this a safety type device? □YES □NO
5. Was safety protection mechanism activated? □Fully □Partially □Not at all
6. Did exposure occur: □ Before □ During □ After safety activation? □YES □NO

Supervisor Signature: Date Completed:

EMPLOYEE INJURY REPORT

CERTIFICATE FOR RETURN TO WORK STATUS

TO BE COMPLETED BY UHS STAFF
(Please Print Legibly)

Employee Name: _____ Date of Injury: _____

CWID: _____ Under my care: _____ to _____

Can patient work?

□ YES □ NO

If **yes**, please see modifications or identify the return to work date below If **no**, please advance to diagnosis

Only complete if patient is able to return to work.	**NO**	**LIMITED**	**MODIFICATIONS**	**NO**	**LIMITED**	**MODIFICATIONS**
	□	□	Lifting over_____lbs	□	□	Repetitive lifting
Identify a date below if applicable:	□	□	Pulling	□	□	Repetitive bending
	□	□	Pushing	□	□	Use right arm/hand
Modified work:_____	□	□	Bending	□	□	Use left arm/hand
	□	□	Squatting	□	□	Must use crutches
	□	□	Climbing	□	□	Must wear splint/sling
Regular work:_____	□	□	Overhead reaching	□	□	_____ hours work/day
	□	□	Prolonged standing			

Next appointment: _____ Released from care date: _____

Diagnosis: _____

Comments: _____

Employee referred to:

Type of injury:

□ First Aid

□ Medical □ Prescription Given: _____

Physician Name: _____ Date: _____

Physician Signature: _____ Time: _____

REFUSAL OF TREATMENT STATEMENT

This is to certify that I, _____, am refusing medical treatment for an injury occurring on _____(MM/DD/YYYY).

Injured Worker Signature: _____ Date: _____

TO BE COMPLETED BY ADMINISTRATIVE UNIT/SUPERVISOR				
SUBMISSION INFORMATION Broadspire email: nol@choosebroadspire.com Workers' Comp email: workerscomp@okstate.edu Environmental Health Safety: ohsp@okstate.edu				
Parent Company: Oklahoma State Univ.	**Address:** 106 Whitehurst Stillwater, OK 74078	**County:** Payne	**Phone:** 405.744.5449 **Fax:** 405.744.8345	**Nature of Business:** University
Employee Name as shown in Banner (Last, First MI):			CWID:	
Location Code/Organizational Code (required):		Position Class Code:	Date of Hire (required) (mm/dd/yy): / /	
Employment Status: □ Full-time □ Part-time		Pay Type: □ Monthly □ Bi-weekly	Gross Wages: $ □ Hourly □ Monthly	
Shift/work begins at: □AM □PM		Hours per day:	Days per week:	Hours per week:

CLAIM NUMBER:_____BROADSPIRE

TO SEND CLAIM NUMBER TO*: _____

EMAIL: _____

*Broadspire will send an email notice of the initial claim (including claim number) to EHS at ohsp@okstate.edu and to the individual listed in the space provided above within 24 hours of receipt.
*If the injury was not reported within 5 days of occurring, please obtain in writing from the employee or supervisor as