

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.

TO BE COMPLETED BY EMPLOYEE. **All fields must be completed** (Please Print Legibly)					
Name as on Social Security Card:	CWID:	Sex:	Phone Number	Date of Birth:	
Last: First: MI:			Home: () Work: ()		
Home Mailing Address:					
Street:		City:	State:	Zip:	
Dept/Unit Name:			Job Title:		
Injury Date: / /			Time: <input type="checkbox"/> AM <input type="checkbox"/> PM		
Location of Injury: Room #:			Building:		
Body Part Injured: Finger _____ Hand _____ (Right/Left) Arm_Leg _____ _____ (Right/Left) Torso _____ Head _____ Other: _____			Witness Name(s):		
Was injury reported on date it occurred: <input type="checkbox"/> YES <input type="checkbox"/> NO If NO , please explain:					
To Whom Reported:					
Date/Time Reported:					
Did you seek medical attention before reporting: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , provide Dr. and explanation:					
Dr. Name:		Address:		Phone:	
Describe how and what happened to cause injury: Did Dr. require NO WORK for more than 3 days? <input type="checkbox"/> YES <input type="checkbox"/> NO Has body part been injured before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes , provide date of injury, Dr Name and treatment details:					
Supervisor’s Name:		Supervisor’s Phone:		Was Supervisor notified: <input type="checkbox"/> YES <input type="checkbox"/> NO If NO , explain:	
Employee Signature:			Date Completed:		

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TO BE COMPLETED BY SUPERVISOR (Please Print Legibly)		
Supervisor Name:	Employee Name:	Injured on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO
Supervisor Phone:	Employee CWID:	Were others injured in this incident? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the injury questionable? <input type="checkbox"/> YES <input type="checkbox"/> 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
<input type="checkbox"/> Struck by _____ <input type="checkbox"/> Caught in/under/between <input type="checkbox"/> Overexertion <input type="checkbox"/> Patient handling <input type="checkbox"/> Material handling <input type="checkbox"/> Fall/slip/trip <input type="checkbox"/> Chemical or other exposure <input type="checkbox"/> Body fluid splash <input type="checkbox"/> Needle stick or sharps injury <input type="checkbox"/> Other _____	<input type="checkbox"/> Equipment defect or failure <input type="checkbox"/> PPE (personal protective equipment) unavailable <input type="checkbox"/> Work area set-up/arrangement <input type="checkbox"/> Floor/work surfaces <input type="checkbox"/> Ventilation <input type="checkbox"/> Lighting <input type="checkbox"/> Disassembling equipment <input type="checkbox"/> Safety device not activated (needle/sharp) <input type="checkbox"/> Lack of Training <input type="checkbox"/> Other _____	<input type="checkbox"/> Inattention to task <input type="checkbox"/> Rushing or hurried <input type="checkbox"/> Failure to get assistance <input type="checkbox"/> Not using assistive device (lift equipment) <input type="checkbox"/> Procedure not followed <input type="checkbox"/> Unbalanced/poor position or motion <input type="checkbox"/> Bypassing safety device <input type="checkbox"/> Failure to wear PPE <input type="checkbox"/> Lack of experience by other person(s) <input type="checkbox"/> Other
Action Taken to Prevent Reoccurrence: (Check)		
<input type="checkbox"/> Scheduled safety training <input type="checkbox"/> Developed/revised safety procedure <input type="checkbox"/> Ordered PPE <input type="checkbox"/> Took equipment out of service for repair/replacement <input type="checkbox"/> Reviewed policy/procedure	<input type="checkbox"/> Ordered or posted hazard/warning signs <input type="checkbox"/> Reported equipment/condition to _ <input type="checkbox"/> Counseled Employee _ <input type="checkbox"/> Corrective Action _ <input type="checkbox"/> Other _____	
For Needle Stick/Sharps Injury: (Check) <input type="checkbox"/> Patient Room <input type="checkbox"/> ER <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> Lab <input type="checkbox"/> Other: _		
1. Exposed Substance: <input type="checkbox"/> Human blood <input type="checkbox"/> Non-human blood <input type="checkbox"/> Blood fluid Did employee bleed? <input type="checkbox"/> YES <input type="checkbox"/> NO Was visible blood on device? YES NO		
2. When did incident occur? <input type="checkbox"/> During use <input type="checkbox"/> Between steps <input type="checkbox"/> After us but before disposal <input type="checkbox"/> During disposal <input type="checkbox"/> Sharp left in wrong place		
3. Procedure was: <input type="checkbox"/> Blood draw <input type="checkbox"/> Injection <input type="checkbox"/> Start IV <input type="checkbox"/> IV flush <input type="checkbox"/> Cutting <input type="checkbox"/> Suturing <input type="checkbox"/> Other		
4. Sharp product type/brand/mode _____ Was this a safety type device? <input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Was safety protection mechanism activated? <input type="checkbox"/> Fully <input type="checkbox"/> Partially <input type="checkbox"/> Not at all		
6. Did exposure occur: <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After safety activation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supervisor Signature:		Date Completed:

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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?						
<input type="checkbox"/> YES			<input type="checkbox"/> 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
Identify a date below if applicable: _____	<input type="checkbox"/>	<input type="checkbox"/>	Lifting over _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive lifting
Modified work: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive bending
Regular work: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Use right arm/hand
	<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	Use left arm/hand
	<input type="checkbox"/>	<input type="checkbox"/>	Squatting	<input type="checkbox"/>	<input type="checkbox"/>	Must use crutches
	<input type="checkbox"/>	<input type="checkbox"/>	Climbing	<input type="checkbox"/>	<input type="checkbox"/>	Must wear splint/sling
	<input type="checkbox"/>	<input type="checkbox"/>	Overhead reaching	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours work/day
	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged standing			
Next appointment: _____ Released from care date: _____						
Diagnosis: _____						
Comments: _____						
Employee referred to: _____						
Type of injury:						
<input type="checkbox"/> First Aid						
<input type="checkbox"/> Medical <input type="checkbox"/> 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: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Pay Type: <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly		Gross Wages: \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly	
Shift/work begins at: <input type="checkbox"/> AM <input type="checkbox"/> 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 to why there was a delay in reporting.