EMPLOYEE INJURY REPORT

INSTRUCTIONS: To meet OSU policy requirements, employees must report all work place injuries to their supervisor and the Safety Coordinator. This form should be completed **before** employees go to the Health Care Center (HCC). If the injury is serious*, go **immediately** to HCC or dial 911. Failure to complete this form may delay compensation benefits and may result in corrective action.

TO BE COMPLETED BY EMPLOYEE

Last Name First Mid Init.	CWID:	Sex: ___M ___F	Birthdate: (mm/dd/yy) ___/___/___	Work Phone#:_____ Home Phone#:_____
_____	_____			

Dept/Unit Name:	Job Title:	Where did injury occur? Location: Rm #_____ Building _____
_____	_____	

Date of Injury (mm/dd/yy): ___/___/___ Time ___:___ AM/PM (Circle One)	Body Part Injured: Finger___ Hand___ (Right/Left) Arm___ (Right/Left) Head ___ Torso ___ Leg___(Right/Left) Other _____	Witness Name(s) and Phone #:

Was injury reported on date it occurred? ___YES ___ NO If NO, please explain.

To whom was the injury reported?

What was the date/time reported?

Did you seek medical attention for this injury prior to reporting it? ___YES ___No If YES, please explain.

Did the injury require time off from work? __YES __NO If YES, please indicate amount of time (Hours) taken.

Supervisor's Name:	Supervisor's Phone#:	Was supervisor notified of incident? ___YES ___NO If NO, please explain.

Describe how and what happened to cause this injury:

Has body part been injured before? ___YES ___NO If YES, please explain.

Employee Signature:_____ Date Completed: ___/___/_____

*OSHA defines *serious* as 24 hour inpatient hospitalization, permanent disfigurement, loss of body part or death.

TO BE COMPLETED BY SUPERVISOR		
Employee's Department #:	Injured on employer's premises? ____YES ____NO	Were others injured in this incident? ___YES ____NO

Is this a questionable case? __YES ___NO If YES, please explain.

How could this injury have been prevented? (Note: "Be more careful" is not an adequate response.)

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

Type of Event	Contributing Condition	Contributing Behavior
__Struck by (what) _____ __Caught in/under/between __Overexertion __Patient Handling __Material Handling __Fall/Slip/Trip __Chemical or other exposure __Body fluid splash __Needlestick or Sharps __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 _____
__Other _____

Supervisor's Signature:	Phone #:	Date Completed: (mm/dd/yy) ___/___/____

TO BE COMPLETED BY A PHYSICIAN			
___First Aid ___Medical	Estimated Disability: __None __Minimal/Mildly Restrictive __Disabling __Permanently Disabling __Death	Will employee lose time from work? __YES __NO If YES, approximate time:_____	Will employee be able to return to the same job? __YES __NO
Was employee removed by ambulance? __YES __NO Was employee hospitalized? __YES __NO If YES, where?		Is the employee to return for checkup/treatment? __YES __NO If YES, when? _____	
Able to return to work (mm/dd/yy): __/__/___	Restrictions, if any:		
Was the employee referred to another physician/healthcare provider? If so, to whom?			
Treated by:_____ Date __/__/____			

LEAVE COMPLETED FORM IN THE SAFETY COORDINATOR'S MAIL BOX AT THE HCC

TO BE COMPLETED BY THE SAFETY COORDINATOR				
BROADSPIRE INFORMATION **PO BOX 25104** **Lehigh Valley, PA 18002-5104** **Claim Submission: 800.753.6737** **Claim Submission Fax: 800.245.9927**				
Parent Company: Oklahoma State University	**Address:** 106 Whitehurst Stillwater, OK 74078	**County:** Payne	**Phone:** 405.744.5449 **Fax:** 405.744.8345	**Nature of Business:** University

Employee Information			
Number of Dependents: _____	Marital Status: _____	Class Code: _____	Date of Hire (mm/dd/yy): ___/___/___
Employment Status: __Full-time __Part-time	Pay Type: __Monthly __Bi-weekly	Gross Wages (Hourly/Monthly): $_____	
Hours per day: ____	Days per week: ____	Hours per week: _____	
Claim Number: _____			

For Needlestick/Sharps Injury:(Check) ___Patient Room ___ER ___OR ___ICU ___Lab ___Other:

1. Exposed Substance: ___Human blood ___Non-human blood___ Blood fluid
   Did you bleed? ____Was visible blood on device? ___
2. When did incident occur? __during use ___between steps ___after use 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 _____
5. Was safety protection mechanism activated? ___Fully ___Partially ____Not At All
6. Did exposure occur ___Before ___During ___After safety activation?

MEDICAL TREATMENT VS FIRST AID

The Occupational Safety and Health Administration (OSHA) requires that injuries resulting in medical treatment be recorded on a log and Reported to them annually. As a State Run Plan, Oklahoma uses the OK 300 Log for such purposes. In order to determine whether an injury must be recorded and, therefore, reported, the following criteria should be used:

- Medical treatment means the management and care of a patient to combat disease or disorder. For the purpose of determining RECORDABILITY, **medical treatment does not include**:
  - Visits to a physician or other licensed health care professional solely for observation or counseling.
  - Conducting of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes. (e.g. eye drops to dilate pupils)
  - First Aid, such as the following:
    - ✓ Use of a non-prescription medication at nonprescription strength.
      NOTE: For medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for Recordability purposes.
    - ✓ Administering Tetanus immunizations.
    - ✓ **NOTE:** Other immunizations, such as Hepatitis B vaccine or Rabies vaccine are considered medical treatment.
    - ✓ Cleaning, flushing or soaking wounds on the surface of the skin.
    - ✓ Using wound coverings such as bandages, Band-Aids™, gauze pads, butterfly bandages, steri-strips™, etc.
    - ✓ **NOTE:** Other wound closing devices such as sutures, staples, etc., are considered medical treatment.
    - ✓ Using hot or cold therapy.
    - ✓ Use of non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
    - ✓ **NOTE:** Devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment.
    - ✓ Using temporary immobilization devices while transporting an accident victim, such as splints, slings, neck collars, back boards, etc.
    - ✓ Using eye patches.
    - ✓ Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister.
    - ✓ Removing foreign bodies from the eye using only irrigation or a cotton swab.
    - ✓ Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.
    - ✓ Using finger guards.
    - ✓ Drinking fluids for relief of heat stress.

The above list is intended to be all inclusive. Other treatments, including physical therapy or chiropractic treatment **are** considered to be medical treatment, therefore, recordable.