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: Last: First: MI:	CWID:	Sex:	Phone Number Home: ( ) Work: ( )	Date of Birth:

Home Mailing Address:
Street: City: State: Zip:

Dept/Unit Name:	Job Title:
Injury Date: / /	**Time:** ☐ AM ☐ 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: ☐ 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:

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:

Supervisor's Name:	Supervisor's Phone:	Was Supervisor notified: ☐YES ☐NO If **NO**, explain:

Employee Signature: Date Completed:

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 — If **yes**, please see modifications or identify the return to work date below

☐ NO — 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 to why there was a delay in reporting.