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

<table>
<tr><th colspan="6">TO BE COMPLETED BY EMPLOYEE
(Please Print Legibly)</th></tr>
<tr><td colspan="2">Name as on Social Security Card:
Last First MI</td><td>CWID:</td><td>Sex:</td><td colspan="2">Phone Number
Home: ( )
Work: ( )</td><td>Date of Birth:</td></tr>
<tr><td colspan="7">Home Mailing Address:

Street: City: State: Zip:</td></tr>
<tr><td colspan="3">Dept/Unit Name:</td><td colspan="4">Job Title:</td></tr>
<tr><td colspan="7">Location of Injury: Room #: Building:</td></tr>
<tr><td colspan="2">Injury Date: / /

Time: □AM □PM</td><td colspan="3">Body Part Injured:
Finger___ Hand____ (Right/Left)
Arm___ Leg____(Right/Left)
Torso____ Head____
Other:</td><td colspan="2">Witness Name(s):</td></tr>
<tr><td colspan="7">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="7">Describe how and what happened to cause injury:

Did Dr. require NO WORK for 3 days or more? □YES □NO

Has body part been injured before? □YES □NO If YES, explain:</td></tr>
<tr><td colspan="2">Supervisor's Name:</td><td colspan="2">Supervisor's Phone:</td><td colspan="3">Was Supervisor notified: □YES □NO
If NO, explain:</td></tr>
<tr><td colspan="7">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)

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 se-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: _____ □ **First Aid**

CWID: _____ □ **Medical**

Date of Injury: _____

Under my care: _____ to _____

WORK STATUS	**DATE**	**NO**	**LIMITED**	**MODIFICATIONS**	**NO**	**LIMITED**	**MODIFICATIONS**
No work:	_____	□	□	Lifting over _____lbs	□	□	Repetitive lifting
		□	□	Pulling	□	□	Repetitive bending
Modified work:	_____	□	□	Pushing	□	□	Use right arm/hand
		□	□	Bending	□	□	Use left arm/hand
Regular work:	_____	□	□	Squatting	□	□	Must use crutches
		□	□	Climbing	□	□	Must wear splint/sling
Next appt:	_____	□	□	Overhead reaching	□	□	___ hours work/day
		□	□	Prolonged standing	□	□	_____
Released:	_____						

Diagnosis:_____

Comments:_____

Employee referred to:

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 Fax: 800.245.9927 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 on HRS (Last, First MI):			CWID:	
Loc Code (ex. AA-D0401):		Class Code:	Date of Hire (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.