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 the 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:** Work Health Solutions 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:	1	State:	Zip:	,			
Dept/Unit Name:		Job Title:						
Injury Date: / /		Time:	□AM	□PM				
Location of Injury: Room #:	Building:							
Body Part Injured: FingerHand(Right/Left) Arm_Leg(Right/Left) TorsoHead Other:								
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:								
Dr. Name: Address: Phone:								
Describe how and what happened to cause inj	ury:							
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:		s Supervisor notified O , explain:	l: □YES	□NO			
Employee Signature: Date Completed:								

EMPLOYEE INJURY REPORT

TO BE COMPLETED BY SUPERVISOR (Please Print Legibly)							
Supervisor Name:	Employee Name:	Injured on employer's premises?					
Supervisor Phone:	Employee CWID:	☐ YES☐ NOWere others injured in this incident?☐ YES☐ NO					
Is the injury questionable? \Box YES \Box 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							
his injury?							
Type of Event	Contributing Condition	Contributing Behavior					
□Struck by	☐ Equipment defect or failure	□ Inattention to task					
□ Caught in/under/between	□PPE (personal protective	□ Rushing or hurried					
□ Overexertion	equipment) unavailable	□ Failure to get assistance					
□ Patient handling	□ Work area set-up/arrangement	Not using assistive device					
□ Material handling	□ Floor/work surfaces	ft equipment)					
□ Fall/slip/trip	□ Ventilation	Procedure not followed					
☐ Chemical or other exposure	□ Lighting	☐ Unbalanced/poor position or motion					
□ Body fluid splash	□ Disassembling equipment	□ Bypassing safety device					
□ Needle stick or sharps injury	□ Safety device not	☐ Failure to wear PPE					
□ Other	activated (needle/sharp)	☐ Lack of experience by other person(s)					
	□ Lack of Training	□ Other					
	□ Other						
Action Taken to Prevent Reoccurrence: (Check)							
□ Scheduled safety training □ Ordered or posted hazard/warning signs							
□ Developed/revised safety procedure □ Reported equipment/condition to □							
□ Ordered PPE □ Counseled Employee □							
□ Took equipment out of service for repair/replacement □ Corrective Action □							
□ Reviewed policy/procedure □ Other □							
For Needle Stick/Sharps Injury: (Check)							
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							
 Sharp product type/brand/modewas this a safety type device: ☐ TES ☐ INO Was safety protection mechanism activated? ☐ Fully ☐ Partially ☐ Not at all 							
6. Did exposure occur: ☐ Before ☐ During ☐ After safety activation? ☐ YES ☐ NO							
5. S.a S. postaro dodari. El Barring El Artor daroty dottivation. El Ed El 10							
Supervisor Signature:	Date Completed	d:					

EMPLOYEE INJURY REPORT

CERTIFICATE FOR RETURN-TO-WORK STATUS

			COMPLETE (Please Pri	D BY UHS ST. nt Legibly)	AFF				
Employee Name:				Date of Injury:					
CWID:				Under my care:to					
Employee's Supervisor:									
	Can patient				Supervisor's Phone Number:				
☐ YES		·	an patient	WOIK: □ 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	MODIFIC	CATIONS	NO	LIMITED	MODIFICATIONS		
			Lifting ov	erlbs			Repetitive lifting		
Identify a date below if applicable:			Pulling				Repetitive bending		
			Pushing				Use right arm/hand		
Modified work:			Bending				Use left arm/hand		
			Squattin	~			Myst use crutches		
			Climbing	•			Must wear splint/sling		
Regular work:				d reaching d standing			hours work/day		
Next appointment:		Relea	ased from o	are date:					
Diagnosis:									
Comments:									
Employee referred to:									
Type of injury:									
□ First Aid									
□ Medical □] Prescr	iption Giver	1:						
Physician Name:					Date:				
Physician Signature:					Time: _				
		REFUSAL	OFTREAT	MENT STATEM	1ENT				
This is to certify that I,, am refusing medical treatment for an injury									
occurring on(MM	1/DD/Y\	YY).							
Injured Worker Signature:					Γ	oate:			

TO BE COMPLETED BY ADMINISTRATIVE UNIT/SUPERVISOR									
SUBMISSION INFORMATION									
Broadspire email: nol@choosebroadspire.com									
Workers' Comp email: workerscomp@okstate.edu									
_					nsp@	okstate.edu		T	
Parent Company:	Address: 401		idemic Bldg.	County:		Phone: 405.744.7401		Nature of Business:	
Oklahoma State Univ. Stillwater, OK 74078 Payne Fax: 405.744.7872						1			
Employee Name as shown in Banner (Last, First MI):						CWID:			
Location Code/Organizational Code (required): Position Code			Position C	lass Code:	Date of Hire (required) (mm/dd/yy):		1 1		
Employment Status:	□ Full-time	Pay Typ	Pay Type: Monthly				□ Hourly		
	□ Part-time		□ Bi-weekly		Gro	Gross Wages: \$		☐ Monthly	
	□AM								
Shift/work begins at:	□PM	Hours p	Hours per day:		Days per week:		F	lours 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									