Employee Injury Report Guide

- ALL portions of page 1 to be completed by EMPLOYEE, page 2 to be completed by SUPERVISOR, and page 4 must be completed by DEPARTMENT ADMIN. Upon completion of the EIR, the EIR must be submitted to:
  First Aid claims: workerscomp@okstate.edu and ohsp@okstate.edu
  Medical claims: nol@choosebroadspire.com, workerscomp@okstate.edu, and ohsp@okstate.edu

- Page 3 – Stillwater Campus: top portion to be completed by UHS. All Campuses: Must complete Refusal of Treatment if the employee is not seeking treatment.

- **You must seek treatment at an approved facility. Seeking treatment elsewhere for a work-related injury or illness could result in the employee being responsible for the cost of medical treatment. STILLWATER EMPLOYEES**: Page 3 will be completed by University Health Services. Neither AMC Urgent Care nor the SMC Emergency Room will complete page 3, however, all paperwork received from either AMC Urgent Care or SMC Emergency Room, must be submitted with pages 1, 2, and 4. ***Do not seek treatment at the Rezilient Clinic.***

  - If you seek treatment somewhere other than University Health Services (UHS), you must be seen at UHS on the first day they are open after your work-related injury/illness. Only UHS can make necessary referrals and set restrictions, *if needed*. If you are referred to another medical professional, they can set any needed restrictions. **Do not follow-up with your primary care physician.**

  - Failure to turn in complete Employee Injury Reports and follow proper protocol could result in failure of timely payments for wages and medical bills.

  - Employees MUST submit all follow-up medical documentation to their supervisor or department admins promptly after appointments.

CAMPUS INFORMATION & CONTACTS

OSU-Stillwater		
Toby Venable, Absence Management Specialist	405-744-7401	wokerscomp@okstate.edu
Kim Southworth, Occupational Safety Manager	405-744-7241	ohsp@okstate.edu
OSU-Tulsa/CHS		
OSU Tulsa/CHS Human Resources	918-594-8221	tulsa.hr@okstate.edu
Patty White, Safety Manager	918-561-8391	patty.white@okstate.edu
OSU-OKC		
Melissa Herren, HR Director	405-945-3298	okc.humanresources@okstate.edu
OSUIT (Okmulgee)		
Brooke Cook, HR Director	918-293-5238	OSUIT-HR@okstate.edu

EMPLOYEE INJURY REPORT

Page 1

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: Concentra Urgent Care.**

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, doctors 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

Page 2

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 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? ☐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 _____
Employee's Supervisor: _____	Supervisor's Phone Number: _____

Can patient work?

☐ YES ☐ 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**
	☐	☐	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 *(**only** email to workerscomp@okstate.edu and ohsp@okstate.edu)*

□ Medical ☐ Prescription Given: _____

Physician Name:_____ Date: _____

Physician Signature:_____ Time: _____

REFUSAL OF TREATMENT STATEMENT

only send to workerscomp@okstate.edu and ohsp@okstate.edu

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

Claims marked MEDICAL on page 3, go to all three.

Parent Company: Oklahoma State Univ.	**Address:** 201 General Academic Bldg. Stillwater, OK 74078	**County:** Payne	**Phone:** 405.744.7401 **Fax:** 405.744.7872	**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.**

Where to find requested information in Banner:
PEAEMPL: Location Code/Organizational Code, Position Class Code and Date of Hire
NBAJOBS: Gross Wages