

## 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.

<b>TO BE COMPLETED BY EMPLOYEE</b> (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:	
Location of Injury: Room #:		Building:		
Injury Date:    /    /  Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Body Part Injured: Finger___Hand___(Right/Left) Arm___Leg___(Right/Left) Torso___Head___      Other:		Witness Name(s):	
Was injury reported on date it occurred: <input type="checkbox"/> YES <input type="checkbox"/> NO    if NO, please explain:				
To Whom Reported:				
Date/Time Reported:				
Did you seek medical attention before reporting: <input type="checkbox"/> YES <input type="checkbox"/> 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 3 days or more? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Has body part been injured before? <input type="checkbox"/> YES <input type="checkbox"/> NO      If YES, explain:				
Supervisor's Name:		Supervisor's Phone:		Was Supervisor notified: <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain:
Employee Signature:			Date Completed:	

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TO BE COMPLETED BY SUPERVISOR (Please Print Legibly)		
Supervisor Name:	Employee Name:	Injured on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO
Supervisor Phone:	Employee CWID:	Were others injured in this incident? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the injury questionable? <input type="checkbox"/> YES <input type="checkbox"/> 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
<input type="checkbox"/> Struck by _____ <input type="checkbox"/> Caught in/under/between <input type="checkbox"/> Overexertion <input type="checkbox"/> Patient handling <input type="checkbox"/> Material handling <input type="checkbox"/> Fall/slip/trip <input type="checkbox"/> Chemical or other exposure <input type="checkbox"/> Body fluid splash <input type="checkbox"/> Needle stick or sharps injury <input type="checkbox"/> Other	<input type="checkbox"/> Equipment defect or failure <input type="checkbox"/> PPE (personal protective equipment) unavailable <input type="checkbox"/> Work area se-up/arrangement <input type="checkbox"/> Floor/work surfaces <input type="checkbox"/> Ventilation <input type="checkbox"/> Lighting <input type="checkbox"/> Disassembling equipment <input type="checkbox"/> Safety device not activated (needle/sharp) <input type="checkbox"/> Lack of Training <input type="checkbox"/> Other	<input type="checkbox"/> Inattention to task <input type="checkbox"/> Rushing or hurried <input type="checkbox"/> Failure to get assistance <input type="checkbox"/> Not using assistive device (lift equipment) <input type="checkbox"/> Procedure not followed <input type="checkbox"/> Unbalanced/poor position or motion <input type="checkbox"/> Bypassing safety device <input type="checkbox"/> Failure to wear PPE <input type="checkbox"/> Lack of experience by other person(s) <input type="checkbox"/> Other
<b>Action Taken to Prevent Reoccurrence: (Check)</b>		
<input type="checkbox"/> Scheduled safety training <input type="checkbox"/> Developed/revised safety procedure <input type="checkbox"/> Ordered PPE <input type="checkbox"/> Took equipment out of service for repair/replacement <input type="checkbox"/> Reviewed policy/procedure	<input type="checkbox"/> Ordered or posted hazard/warning signs <input type="checkbox"/> Reported equipment/condition to _ <input type="checkbox"/> Counseled Employee _ <input type="checkbox"/> Corrective Action _ <input type="checkbox"/> Other _	
<b>For Needle Stick/Sharps Injury: (Check)</b> <input type="checkbox"/> Patient Room <input type="checkbox"/> ER <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> Lab <input type="checkbox"/> Other: _		
1. Exposed Substance: <input type="checkbox"/> Human blood <input type="checkbox"/> Non-human blood <input type="checkbox"/> Blood fluid Did employee bleed? <input type="checkbox"/> YES <input type="checkbox"/> NO      Was visible blood on device?   YES   NO		
2. When did incident occur? <input type="checkbox"/> During use <input type="checkbox"/> Between steps <input type="checkbox"/> After us but before disposal <input type="checkbox"/> During disposal <input type="checkbox"/> Sharp left in wrong place		
3. Procedure was: <input type="checkbox"/> Blood draw <input type="checkbox"/> Injection <input type="checkbox"/> Start IV <input type="checkbox"/> IV flush <input type="checkbox"/> Cutting <input type="checkbox"/> Suturing <input type="checkbox"/> Other		
4. Sharp product type/brand/mode _____ Was this a safety type device? <input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Was safety protection mechanism activated? <input type="checkbox"/> Fully <input type="checkbox"/> Partially <input type="checkbox"/> Not at all		
6. Did exposure occur <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After safety activation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supervisor Signature:		Date Completed:

**EMPLOYEE INJURY REPORT**

CERTIFICATE FOR RETURN TO WORK STATUS

<b>TO BE COMPLETED BY UHS STAFF</b> (Please Print Legibly)							
Employee Name: _____				Date of Injury: _____			
CWID: _____		<input type="checkbox"/> <b>First Aid</b> <input type="checkbox"/> <b>Medical</b>		Under my care: _____ to _____			
WORK STATUS	DATE	NO	LIMITED	MODIFICATIONS	NO	LIMITED	MODIFICATIONS
No work: _____		<input type="checkbox"/>	<input type="checkbox"/>	Lifting over _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive lifting
Modified work: _____		<input type="checkbox"/>	<input type="checkbox"/>	Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive bending
Regular work: _____		<input type="checkbox"/>	<input type="checkbox"/>	Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Use right arm/hand
Next appt: _____		<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	Use left arm/hand
Released: _____		<input type="checkbox"/>	<input type="checkbox"/>	Squatting	<input type="checkbox"/>	<input type="checkbox"/>	Must use crutches
		<input type="checkbox"/>	<input type="checkbox"/>	Climbing	<input type="checkbox"/>	<input type="checkbox"/>	Must wear splint/sling
		<input type="checkbox"/>	<input type="checkbox"/>	Overhead reaching	<input type="checkbox"/>	<input type="checkbox"/>	hours work/day
		<input type="checkbox"/>	<input type="checkbox"/>	Prolonged standing	<input type="checkbox"/>	<input type="checkbox"/>	-
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 email: [nol@choosebroadspire.com](mailto:nol@choosebroadspire.com)  
Workers' Comp email: [workerscomp@okstate.edu](mailto:workerscomp@okstate.edu)  
Environmental Health Safety: [ohsp@okstate.edu](mailto:ohsp@okstate.edu)

<b>Parent Company:</b> Oklahoma State Univ	<b>Address:</b> 106 Whitehurst Stillwater, OK 74078	<b>County:</b> Payne	<b>Phone:</b> 405.744.5449 <b>Fax:</b> 405.744.8345	<b>Nature of Business:</b> University
Employee Name as shown on HRS (Last, First MI):				CWID:
Loc Code (ex. 100452):		Class Code:	Date of Hire (mm/dd/yy):    /    /	
Employment Status:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Pay Type:	<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly
Shift/work begins at:	<input type="checkbox"/> AM <input type="checkbox"/> PM	Hours per day:	Days per week:	Hours per week:
<b>CLAIM NUMBER:</b> _____ <b>BROADSPIRE</b>				
<b>TO SEND CLAIM NUMBER TO*:</b> _____				
<b>EMAIL:</b> _____				
*Broadspire will send an email notice of the initial claim (including claim number) to EHS at <a href="mailto:ohsp@okstate.edu">ohsp@okstate.edu</a> and to the individual listed in the space provided above within 24 hours of receipt.				