

## Broadspire Workers' Compensation Reporting Form

To report the injury the Department Supervisor must be prepared to answer the questions listed below.  
Please forward to Human Resources after information has been completed.

### A. Completed by Human Resources

Is this an Emergency Claim:  Yes  No      Reported by: \_\_\_\_\_ Title: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_      Fax: (\_\_\_\_) \_\_\_\_\_      E-mail: \_\_\_\_\_

### B. Completed by Employee/Supervisor

Date of Accident (mm/dd/yy): \_\_\_\_\_      Time of Accident (hh:mm am/pm): \_\_\_\_\_

### C. Employer Information

Parent Company Name: Oklahoma State University      Department: Human Resources  
Address: 1801 East 4<sup>th</sup> Street      City: Okmulgee      State: OK      Zip: 74447      County: Okmulgee  
Business Phone (918) 293-5240      Fax: (918) 293-4642      E-mail: \_\_\_\_\_  
Location Code: (Division/Dept) \_\_\_\_\_ (example: AA C1015)      Nature of Business: University  
Class Code: (Office/Clerical: OFC or Other: OTH) \_\_\_\_\_

### D. Insured Contact Information (Completed by Human Resources)

Are You the Contact Person:  Yes  No  
**If No**, Enter Contact Name: \_\_\_\_\_      Title: \_\_\_\_\_  
Contact Phone (\_\_\_\_) \_\_\_\_\_      E-mail: \_\_\_\_\_

### E. Loss Location Information

Did Accident Occur on the Insured Premises:  Yes  No  
If No, Enter Physical Address: \_\_\_\_\_      City: \_\_\_\_\_      State: \_\_\_\_      Zip: \_\_\_\_\_      County: \_\_\_\_\_

### F. Employee Information

CWID: \_\_\_\_\_      Employee Name: \_\_\_\_\_      Birthday: \_\_\_\_\_      Age: \_\_\_\_\_  
Address: \_\_\_\_\_      City: \_\_\_\_\_      State: \_\_\_\_      Zip: \_\_\_\_\_      County: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_      Business Phone: (\_\_\_\_) \_\_\_\_\_      Sex:  Female  Male  
Number of Dependents: \_\_\_\_\_      Marital Status: \_\_\_\_\_  
Regular Occupation: \_\_\_\_\_      Regular Department: \_\_\_\_\_      Class Code: \_\_\_\_\_  
Date of Hire: \_\_\_\_\_      Hire County: \_\_\_\_\_      Hire State: \_\_\_\_  
Employment Status:  Full Time  Part Time      Pay Type:  Monthly  Bi-Weekly  
Gross Wages (hourly/monthly): \_\_\_\_\_      Hours per Day: \_\_\_\_      Days per Week: \_\_\_\_\_      Hours per Week: \_\_\_\_\_  
**Supervisor Name:** \_\_\_\_\_      **Business Phone:** (\_\_\_\_) \_\_\_\_\_

### G. Loss Information

Employee Start Time: \_\_\_\_\_      Date Employer Notified: \_\_\_\_\_      Questionable Case:  Yes  No  
Description of Accident: \_\_\_\_\_  
Removed by Ambulance:  Yes  No  Unknown  
Any Stitches/Surgery Required:  Yes  No  Unknown  
Was a Fatality Involved:  Yes  No      (If Yes) Provide Date: \_\_\_\_\_

**H. Loss Information (continued)**

Describe Injury or Illness:

Body Part Injured (Indicate Right or Left): \_\_\_\_\_

Work Process Injured was doing: \_\_\_\_\_

Describe Preventable Measures: \_\_\_\_\_

Direct Cause:      Auto Accident                    Faulty Machinery                    Someone's Negligence

**If other**, Describe Cause: \_\_\_\_\_

Describe Preventable Measures: \_\_\_\_\_

Safeguards or Safety Equipment Provided:              Yes                    No      Unknown

Safeguards or Safety Equipment Utilized:              Yes                    No      Unknown

Employee on Restricted Duty:                              Yes                    No      Unknown

Full Pay for Day of Injury:                                  Yes                    No      Unknown

Any Lost Time:    Yes                    No      Undetermined

Last Day Worked: \_\_\_\_\_ Start Date of Disability: \_\_\_\_\_ Date Returned to Work: \_\_\_\_\_

Salary Continued During Disability:                    Yes                    No      Unknown

**I. Medical Information**

Initial Treatment (Select Only One):    No Medical Treatment    Minor by Employer    Minor Hosp/Clinic  
   Emergency Care            Hospitalized 24 hrs    Future Medical/Lost Time    Unknown

**Physician Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_

**Hospital Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_

**J. Witness Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**To report a claim: Broadspire 1-800-753-6737**

Claim Number: \_\_\_\_\_

**(Employee to keep and give to treating physician/medical facility)**

**WORKERS' COMPENSATION**

**Employee Name:** \_\_\_\_\_

**Claim Number:** \_\_\_\_\_

**Employer: Oklahoma State University**

*Please mail all inquires and bills to:*

**Broadspire Services, Inc. 800-890-8975; 405-387-3960 (fax)  
PO Box 10900  
Overland Park, KS 66225-0900  
ATTN: Lisa Colbert**