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.

TO BE COMPLETED BY EMPLOYEE

Last Name First Mid Init. ________________________________	Campus Wide ID (CWID): _______________	Sex: ___M ___F	Birthdate (mm/dd/yy) ___/___/___	Work Phone#______________ Home Phone#______________

Number of Dependents:	Marital Status:	Home Address:
Dept/Unit Name:		Job Title:

Where did injury occur? Location: Rm # Building:

Date of Injury (mm/dd/yy) ___/___/___ Time ___:___ AM/PM (Circle One)	Body Part Injured. Finger___ Hand___ (Right/Left) Arm___ (Right/Left) Head ___ Torso ___ Leg___(Right/Left) Other ______________________________	Witness Name(s):

Was injury reported on date it occurred? ___YES ___ NO If NO, please explain.

To whom was the injury reported?

What was the date/time reported?

Did you seek medical attention for this injury prior to reporting it? ___YES ___No If YES, please explain.

Did the injury require time off from work? __YES __NO. If YES, please indicate amount of time (hours) taken.

Supervisor's Name	Supervisor's Phone#	Was supervisor notified of incident? ___YES ___NO If NO, please explain.

Describe how and what happened to cause this injury:

Has body part been injured before? ___YES ___NO If YES, please explain.

Employee Signature:___________________________________ Date Completed: ___/___/______

EMPLOYEE INJURY REPORT

TO BE COMPLETED BY SUPERVISOR		
Department Name: ___________________________	Injured on employer's premises? ____YES ____NO	Were others injured in this incident? ___YES ____NO

Is this a questionable case? __YES ___NO. If YES, please explain.

How could this injury have been prevented? (Note: "Be more careful" is not an adequate response.)

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 (what) ________________ __Caught in/under/between __Overexertion __Patient handling __Material handling __Fall/slip/trip __Chemical or other exposure __Body fluid splash __Needlestick 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 Needlestick/Sharps Injury:(Check) ___Patient Room ___ER ___OR ___ICU ___Lab ___Other:

1. Exposed Substance: ___Human blood ___Non-human blood___ Blood fluid
   Did employee bleed? ____Was visible blood on device? ___
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? _________
5. Was safety protection mechanism activated? ___Fully ___Partially ____Not At All

Did exposure occur ___Before ___During ___After safety activation?

Supervisor's Signature:	Phone #:	Date Completed: (mm/dd/yy) ___/___/____

EMPLOYEE INJURY REPORT

CERTIFICATE FOR RETURN TO WORK STATUS

TO BE COMPLETED BY UHS STAFF		
Employee Name ____ has been under my care from ___________ to ____________. Campus Wide ID (CWID)_________________________________ DATE OF INJURY____		
___First Aid ___Medical	Estimated Disability: __None __Minimal/Mildly Restrictive __Disabling __Permanently Disabling __Death	Was employee removed by ambulance? __YES __NO Was employee hospitalized? __YES __NO If YES, where?
Can the employee now return to work/school? __YES __NO If NO, approximate date of return to work (mm/dd/yy): __ /__ /___		Will employee be able to return to the same job? __YES __NO
Restrictions, if any:		Is the employee to return for checkup/treatment? __YES __NO If YES, when?
Was the employee referred to another physician/healthcare provider? If so, to whom?		
Comments:		
Treating Physician:____ Date __ /__ /____		

TO BE COMPLETED BY ADMINISTRATIVE UNIT/SUPERVISOR						
BROADSPIRE INFORMATION **PO BOX 25104** **Lehigh Valley, PA 18002-5104** **Claim Submission: 800.753.6737** **Claim Submission Fax: 800.245.9927**						
Parent Company: Oklahoma State University	**Address:** 106 Whitehurst Stillwater, OK 74078		**County:** Payne	**Phone:** 405.744.5449 **Fax:** 405.744.8345		**Nature of Business:** University
Employee Information						
Loc Code-Div & Dept (ex: AA-D0401):__________________		Class Code: ______		Date of Hire (mm/dd/yy): ___/___/____		
Campus Wide ID (CWID)____________________________						
Employment Status: __Full-time __Part-time	Pay Type: __Monthly __Bi-weekly		Gross Wages (Hourly/Monthly): $_____________			
Hours per day: ____	Days per week: ____			Hours per week: __________		
CLAIM NUMBER:________________ **Broadspire to Send Claim Number to:** _____________________________ **Fax#:**_____________ **E-mail:**____________________ **Telephone:** _____________________						