

EMPLOYEE INJURY REPORT

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. 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
<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 set-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
Action Taken to Prevent Reoccurrence: (Check)		
<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 _____	
For Needle Stick/Sharps Injury: (Check) <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:

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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 _____			
Can patient work?						
<input type="checkbox"/> YES			<input type="checkbox"/> 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. Identify a date below if applicable: Modified work: _____ Regular work: _____	NO	LIMITED	MODIFICATIONS	NO	LIMITED	MODIFICATIONS
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Lifting over _____ lbs Pulling Pushing Bending Squatting Climbing Overhead reaching Prolonged standing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Repetitive lifting Repetitive bending Use right arm/hand Use left arm/hand Must use crutches Must wear splint/sling _____ hours work/day
Next appointment: _____ Released from care date: _____						
Diagnosis: _____						
Comments: _____						
Employee referred to: _____						
Type of injury: <input type="checkbox"/> First Aid <input type="checkbox"/> Medical <input type="checkbox"/> Prescription Given: _____						
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
 Workers' Comp email: workerscomp@okstate.edu
 Environmental Health Safety: ohsp@okstate.edu

Parent Company: Oklahoma State Univ.	Address: 106 Whitehurst Stillwater, OK 74078	County: Payne	Phone: 405.744.5449 Fax: 405.744.8345	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: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Pay Type: <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly	Gross Wages: \$ <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:	

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.