EMPLOYEE INJURY REPORT

INSTRUCTIONS: To meet OSU policy requirements, employees must report all workplace injuries to their supervisor and the Safety Coordinator. This form should be completed before employees go to the Health Care Center (HCC). If the injury is serious*, go immediately to HCC or dial 911. Failure to complete this form may delay compensation benefits and may result in corrective action.

**TO BE COMPLETED BY EMPLOYEE**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Mid Init.</th>
<th>CWID:</th>
<th>Sex:</th>
<th>Birthdate: (mm/dd/yy)</th>
<th>Work Phone#:</th>
<th>Home Phone#:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>_M</td>
<td><em>/<strong>/</strong></em></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dept/Unit Name:</th>
<th>Job Title:</th>
<th>Where did injury occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Location: Rm # Building</td>
</tr>
</tbody>
</table>

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) and Phone #:

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: ___/___/_____

*OSHA defines serious as 24 hour inpatient hospitalization, permanent disfigurement, loss of body part or death.
TO BE COMPLETED BY SUPERVISOR

Employee’s Department #: Injured on employer’s premises? Were others others injured in this incident?

____YES ____NO  ____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) might have prevented this injury?

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Contributing Condition</th>
<th>Contributing Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struck by (what)</td>
<td>Equipment defect or failure</td>
<td>Inattention to task</td>
</tr>
<tr>
<td>Caught in/under/between</td>
<td>PPE (personal protective equipment)</td>
<td>Rushing or hurried</td>
</tr>
<tr>
<td>Overexertion</td>
<td>Unavailable</td>
<td>Failure to get assistance</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>Work area set-up/arrangement</td>
<td>Not using assistive device (lift equipment)</td>
</tr>
<tr>
<td>Material Handling</td>
<td>Floor/work surfaces</td>
<td>Procedure not followed</td>
</tr>
<tr>
<td>Fall/Slip/Trip</td>
<td>Ventilation</td>
<td>Unbalanced/poor position or motion</td>
</tr>
<tr>
<td>Chemical or other exposure</td>
<td>Lighting</td>
<td>Bypassing safety device</td>
</tr>
<tr>
<td>Body fluid splash</td>
<td>Disassembling equipment</td>
<td>Failure to wear PPE</td>
</tr>
<tr>
<td>Needlestick or Sharps</td>
<td>Safety device not activated</td>
<td>Lack of experience by other person(s)</td>
</tr>
<tr>
<td>Other</td>
<td>(needle/sharp)</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Lack of training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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

Supervisor’s Signature: Phone #: Date Completed: (mm/dd/yy)

__/__/____

TO BE COMPLETED BY A PHYSICIAN

- First Aid
- Medical

Estimated Disability: None Minimal/Mildly Restrictive Disabling Permanently Disabling Death

Will employee lose time from work? **YES NO**

If YES, approximate time: ____________________________

Will employee be able to return to the same job? **YES NO**

Was employee removed by ambulance? **YES NO**

Was employee hospitalized? **YES NO**

If YES, where?

Able to return to work (mm/dd/yy): __/__/____

Restrictions, if any:

Was the employee referred to another physician/healthcare provider? If so, to whom?

Treated by: ____________________________ Date __/__/____

LEAVE COMPLETED FORM IN THE SAFETY COORDINATOR’S MAIL BOX AT THE HCC
### TO BE COMPLETED BY THE SAFETY COORDINATOR

**BROADSPIRE INFORMATION**

PO BOX 25104  
Lehigh Valley, PA 18002-5104  
Claim Submission: 800.753.6737  
Claim Submission Fax: 800.245.9927

<table>
<thead>
<tr>
<th>Parent Company:</th>
<th>Address:</th>
<th>County:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>Nature of Business:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma State University</td>
<td>106 Whitehurst Stillwater, OK 74078</td>
<td>Payne</td>
<td>405.744.5449</td>
<td>405.744.8345</td>
<td>University</td>
</tr>
</tbody>
</table>

#### Employee Information

<table>
<thead>
<tr>
<th>Number of Dependents:</th>
<th>Marital Status:</th>
<th>Class Code:</th>
<th>Date of Hire (mm/dd/yy):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employment Status:</th>
<th>Pay Type:</th>
<th>Gross Wages (Hourly/Monthly):</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Full-time</em></td>
<td><em>Monthly</em></td>
<td>$_____________</td>
</tr>
<tr>
<td><em>Part-time</em></td>
<td><em>Bi-weekly</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hours per day:</th>
<th>Days per week:</th>
<th>Hours per week:</th>
</tr>
</thead>
</table>

**Claim Number: ________________________________**

For Needlestick/Sharps Injury: (Check)  
- __Patient Room__  
- __ER__  
- __OR__  
- __ICU__  
- __Lab__  
- __Other__:

1. Exposed Substance:  
- ___Human blood___  
- ___Non-human blood___  
- ___Blood fluid___  

2. Did you bleed? ___  
   Was visible blood on device? ___

3. When did incident occur?  
   - ___During use___  
   - ___Between steps___  
   - ___After use but before disposal___  
   - ___During disposal___  
   - Sharp left in wrong place

4. Procedure was:  
   - ___Blood draw___  
   - ___Injection___  
   - ___Start IV___  
   - ___IV flush___  
   - ___Cutting___  
   - ___Suturing___  
   - ___Other___

5. Sharp product type/brand/mode:  
   _____________________________  
   Was this a safety type device _________

6. Was safety protection mechanism activated?  
   - ___Fully___  
   - ___Partially___  
   - ___Not At All___

7. Did exposure occur?  
   - ___Before___  
   - ___During___  
   - ___After safety activation___

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### MEDICAL TREATMENT VS FIRST AID

The Occupational Safety and Health Administration (OSHA) requires that injuries resulting in medical treatment be recorded on a log and Reported to them annually. As a State Run Plan, Oklahoma uses the OK 300 Log for such purposes. In order to determine whether an injury must be recorded and, therefore, reported, the following criteria should be used:

1. **Medical treatment means** the management and care of a patient to combat disease or disorder. For the purpose of determining RECORDABILITY, **medical treatment does not include**:
   - Visits to a physician or other licensed health care professional solely for observation or counseling.
   - Conducting of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes. (e.g. eye drops to dilate pupils)
   - First Aid, such as the following:
     - Use of a non-prescription medication at nonprescription strength.
     - Administering Tetanus immunizations.
     - Other immunizations, such as Hepatitis B vaccine or Rabies vaccine are considered medical treatment.
     - Cleaning, flushing or soaking wounds on the surface of the skin.
     - Using wound coverings such as bandages, Band-Aids™, gauze pads, butterfly bandages, steri-strips™, etc.
     - Other wound closing devices such as sutures, staples, etc., are considered medical treatment.
     - Using hot or cold therapy.
     - Use of non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
     - Devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment.
   - Using temporary immobilization devices while transporting an accident victim, such as splints, slings, neck collars, back boards, etc.
   - Using eye patches.
   - Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister.
   - Removing foreign bodies from the eye using only irrigation or a cotton swab.
   - Removing splinters or foreign material from other than the eye by irrigation, tweezers, cotton swabs, or other simple means.
   - Using finger guards.
   - Drinking fluids for relief of heat stress.

The above list is intended to be all inclusive. Other treatments, including physical therapy or chiropractic treatment **are considered to be** medical treatment, therefore, recordable.