

**University of Oklahoma Employee's Report of Injury\***- To be completed by the employee in black ink. Must be legible and completed in full. Incomplete forms will be returned to your department. Retain a copy of this report and give a copy to your supervisor. \*Injury includes exposure and/or illness. Retain a copy of this report for your records.

<b>Personal Information:</b>			
Last Name:		First Name:	Middle Name:
Home Address: Street:			
City:		State:	Zip: Home Phone:
Date of Birth	SSN:		Employee ID
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
OU Department:		Work Phone:	
<b>Accident Information:</b>			
Date of Loss:	Time of Loss:	Time workday began:	
Dates off work so far:			
Accident resulted from: <input type="checkbox"/> A Single Incident <input type="checkbox"/> Cumulative Incidents			
Location of Accident- Address:			
Building:		City:	State:
<b>Accident Details:</b>			
Work activity when accident occurred:			
Body parts involved in injury:		Type of injury:	
Object or substance causing injury:			
If SHARPS EXPOSURE, Identify type and brand of object:			
How did the injury occur? (attach additional sheet if needed) :			
<b>Other persons present when the injury occurred:</b>			
Name:	Phone:	Employer:	
Name:	Phone:	Employer:	
<b>Treatment:</b>			
Initial Treatment: <input type="checkbox"/> None <input type="checkbox"/> First Aid <input type="checkbox"/> Physician or Clinic <input type="checkbox"/> Emergency Room			
Was follow up medical treatment required after initial treatment: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Treating Physician - Full Name:			
Address:		City	State: Zip:
<b>Certification and Authorization:</b>			
I hereby declare that I have examined this report of my injury and to the best of my knowledge and belief the information I have supplied is true, correct and complete. I understand that any employee who falsifies this report and commits any other Worker' Compensation fraud is subject to criminal penalties and University disciplinary proceedings up to and including termination.			
Under the Workers' Compensation Act, and injured employee of the University of Oklahoma who received temporary total disability benefits under the Act shall have the option to supplement temporary total disability benefits with any leave accrual available to the injured employee to the extent that the injured employee shall receive full wages. I hereby declare that I have read and understand my option to supplement any temporary total disability benefits under the Workers' Compensation Act.			
I hereby request and authorize you to furnish CCMSI and/or The University of Oklahoma and their representatives, any and all information you may have concerning me, with respect to any illness or injury, medical history, consultation, prescription or treatment, including x-rays, and copies of all hospital records. The information authorized for release may include information regarding a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). A photo copy of this authorization shall be considered as effective as the original.			
Signature:			Date: