

**University of Oklahoma Supervisor's Report of Injury\***- To be completed by the supervisor or department head 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 forward this and the Employee's Report of Injury to your local campus Workers' Compensation Office. \*Note : An injury includes bodily injury, exposure to harmful substances, and resulting illnesses.

<b>Employee's Personal Information:</b>			
Last Name:		First Name:	Middle Name:
Home Address: Street:			
City:		State:	Zip: Home Phone:
Date of Birth	SSN:		Employee ID
OU Department:		Work Phone:	Hire Date:

<b>Accident Information:</b>		
Date of Loss:	Time of Loss:	Time workday began:
Date Employer Notified:	Has Employee Returned To Work?: <input type="checkbox"/> YES <input type="checkbox"/> NO	
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:
Did the accident result in the employees death? <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of death:

<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 sheet to explain injury. Attach sheet to explain.	

<b>Other persons present when the injury occurred:</b>		
Name:	Phone:	Employer:
Name:	Phone:	Employer:

<b>Treatment:</b>			
Initial Treatment: <input type="checkbox"/> None Required <input type="checkbox"/> Refused <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			
Did the employee return to work following medical treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO. If NO, Estimated time off work?			
Treating Physician / Hospital - Name:			
Address:		City	State: Zip:

<b>Supervisor's Information:</b>		
Name:		Did you Witness The Incident? <input type="checkbox"/> YES <input type="checkbox"/> NO
Title:	Phone:	Email:
Campus Address:		
What actions were taken or could have been taken to prevent this type of incident? Attach sheet to explain.		

<b>Certification:</b>	
I declare under penalty of perjury that I have examined all statements contained herein and to the best of my knowledge and belief, they are correct and complete. I understand any person who commits Workers' Compensation fraud, upon conviction, shall be guilty of a felony.	
Signature:	Date:

**HSC:** Return forms via email [donna-burton@ouhsc.edu](mailto:donna-burton@ouhsc.edu); campus mail-SCB 123 Attn: Workers' Comp or FAX: 405-271-3925

**NORMAN:** Return forms: Fax at 405-325-7238 or campus mail-Risk Management, NEL 112

**TULSA:** : Return forms via email [kim-little@OUHSC.edu](mailto:kim-little@OUHSC.edu); campus mail- 1C114 Attn: Workers' Comp or FAX: 918-660-3200