Instructions to Employees for Reporting Work-Related Needle Sticks/Sharps/Exposure

The following is updated information about how to report a needle stick, sharps or splash exposure. Information and materials contained herein apply to Staff, Faculty, Resident Physicians, and most temporary personnel (those not hired through an agency). Employees including physicians are defined as workers hired to provide a service, and are not in business for themselves. Work related exposure is defined as occurring during the course and scope of employment. Needle stick or splash injuries from an unknown source, a source not known to be infected, or not suspected of having infection clinically, should be reported. However, generally, no medical prophylaxis will be administrated.

You are responsible for reporting your injury to your supervisor and you are required to follow all medical instructions. Employees may NOT be evaluated, treated or referred to other OU-Tulsa Staff for any reason. Do not order lab or otherwise attempt to manage a blood exposure yourself. Safeguards in the system depend on the notification of Workers Compensation for appropriate management.

If you sustain an exposure by needle stick or slash injury, or prolonged exposure to damaged skin, report the exposure to your supervisor or attending immediately and complete the following steps:

- Wash site with soap and water. Antiseptic wash is acceptable, but not superior.

- Please report to one of the following clinics:

  MedCenter  
  2929 S. Garnett Road  
  Tulsa, OK  74129  
  (918) 665-1520

  MedCenter South  
  10221 E. 81st St.  
  Tulsa, OK  74133  
  (918) 252-9300

  MedCenter Midtown  
  1623 S. Utica  
  Tulsa, OK  74104  
  (918) 392-5100

Hours: Monday – Saturday 8:00 am – 10:00 pm / Sunday 11:00 am – 7:00pm

- If you sustain the exposure at a teaching hospital, contact Employee Health Services at that facility. If the injury occurs after hours, on weekends or holidays, contact the facility’s Nurse Supervisor through the operator.

  Employees may NOT be evaluated, treated or referred to other OU-Tulsa Staff for any reason. Employees should use the above providers for any and all Workers Comp injuries/illness.


If it is determined you need further assessment or treatment, MedCenter will make that determination and you are expected to follow the treatment protocol.

Fax or email all forms as soon as possible to: Kim-Little@OUHSC.edu. Fax: 660-3200.
OU Tulsa 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.

### Personal Information:
- Last Name:
- First Name:
- Middle Name:
- Home Address: Street:
- City: State: Zip: Home Phone:
- Date of Birth: SSN: Employee ID
- Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
- OU Department: Work Phone:

### Accident Information:
- Date of Loss: Time of Loss: Time workday began:
- Dates off work so far:
- Accident resulted from: [ ] A Single Incident [ ] Cumulative Incidents
- Location of Accident: Address:
- Building: City: State:

### Accident Details:
- 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):

### Other persons present when the injury occurred:
- Name: Phone: Employer:
- Name: Phone: Employer:

### Treatment:
- Initial Treatment: [ ] None [ ] First Aid [ ] Physician or Clinic [ ] Emergency Room
- Was follow up medical treatment required after initial treatment: [ ] YES [ ] NO
- Treating Physician - Full Name:
- Address: City State: Zip:

### Certification and Authorization:
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.
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.

### Personal Information:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address: Street:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>SSN:</td>
<td>Employee ID:</td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU Department:</td>
<td>Work Phone:</td>
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<tr>
<td>Accident resulted from:</td>
<td>A Single Incident</td>
<td>Cumulative Incidents</td>
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<td>Location of Accident: Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building:</td>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

### Accident Details:

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):

### Other persons present when the injury occurred:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
<th>Employer:</th>
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<tbody>
<tr>
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### Treatment:

<table>
<thead>
<tr>
<th>initial Treatment:</th>
<th>None</th>
<th>First Aid</th>
<th>Physician or Clinic</th>
<th>Emergency Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was follow up medical treatment required after initial treatment:</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treating Physician - Full Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
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Signature: | Date:
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(The injured employee can only complete this form)

To Whom It May Concern:

I hereby request and authorize you to furnish CCMSI or their representative, The University of Oklahoma, 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.

I give CCMSI permission to access any workers compensation claims information by using my name and/or my Social Security Number which is stated below.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

NOTICE
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).

NAME (Please print)______________________________

SIGNATURE____________________________________

SSN__________________ DATE OF BIRTH__________

Signed on this _______day of ______________, 20___ at , ______________________ Oklahoma.

Employer: The University of Oklahoma- Tulsa
4502 E. 41st Street, Suite 1C114
Tulsa, OK 74129
FITNESS FOR DUTY REPORT

The treating physician fills out this form after examination. The injured worker is responsible for ensuring a copy is forwarded to the employer.

Patient Name:____________________________________________  Today’s Date:__________________________________________

Date of injury/illness:___________________ Treating Physician:______________________________________

Employer: University of Oklahoma – Tulsa Contact:____________________________

Diagnosis:

Work Status:

1) TIME OFF

☐ None ☐ Today Only ☐ No work from_____________to_____________ (Inclusive)

2) DUTIES

☐ Regular ☐ Modified through_________________as follows (circle and comment)

2a) LIMITATIONS

<table>
<thead>
<tr>
<th>Modifications</th>
<th>Limited</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use right arm/hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use left arm/hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must use crutches</td>
<td></td>
<td></td>
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<tr>
<td>Must wear splint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifting over _______ lbs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifications</th>
<th>Limited</th>
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<tbody>
<tr>
<td>Repetitive lifting</td>
<td></td>
<td></td>
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<tr>
<td>Repetitive bending</td>
<td></td>
<td></td>
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<tr>
<td>Bending</td>
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<tr>
<td>Squatting</td>
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<tr>
<td>Climbing</td>
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<tr>
<td>Overhead reaching</td>
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<td></td>
</tr>
<tr>
<td>Twisting</td>
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</tr>
</tbody>
</table>

Additional instructions: ________________________________________________________________
_____________________________________________________________________________________

Medication prescribed / instructions: _____________________________________________________
_____________________________________________________________________________________

TETANUS BOOSTER (circle): ☐ Yes ☐ No DRUG SCREEN (circle) ☐ Yes ☐ No

FOLLOW-UP: ______________________________ Date-Time of Appointment

REFERRALS:

Physical Therapy: ______________________________ Location: ______________________________

Evaluate and treat with other physician: _____________________________________________________

Second opinion with other physician: _______________________________________________________

PATIENT/EXAMINEE ACKNOWLEDGEMENT: I have read and understand the above.

Patient/ Examinee Signature:____________________________________________________ Date:________

Physician’s name:_________________________________ Physician’s Signature:_________________________________