University of Oklahoma "Employee's Report of Injury" – To be completed by the employee in black ink. Must be legible and completed in full. Retain a copy for records and give the original to your supervisor. "Injury" includes exposure and/or illness. (Updated June 2016)

Personal Information:			
Last Name:	First Name:	Middle Name:	
Home Address Street:			
City:	State:	Zip:	Phone:
Date of Birth	SSN:	Employee ID:	
Marital Status: Married ◯ Unmarried ◯ Separated ◯		Sex: Male ◯ Female ◯	
OU Department:		Work Phone:	
Department Address:			
Injury Information:			
Date of Injury:	Time of Injury:	Time Workday Began:	
Dates Anticipate Being off Work:			
Injury resulted from: A Single Incident ◯ Cumulative Incidents ◯			
Location of Injury:			
Building:	City:	State:	
Injury Details:			
Work activity when injury 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 injury occurred:			
Name:	Phone:	Employer:	
Name:	Phone:	Employer:	
Treatment:			
None ◯ First Aid ◯ Physician or Clinic ◯ Emergency Room ◯			
Was follow-up treatment needed after initial treatment: Yes ◯ No ◯			
Treating Physician-Full Name:		Phone:	
Address:	City:	State:	Zip:
Certification:			
I hereby declare that the information I have supplied is true, correct and complete to the best of my knowledge and belief. I understand that any employee who falsifies this Report and commits fraud is subject to criminal penalties and University disciplinary proceedings up to and including termination. Under the Workers' Compensation Act an employee of the University of Oklahoma who receives temporary total disability (TTD) benefits have the option to supplement TTD benefits with any leave accrual available to the extent that the injured employee receives full wages while unable to work pursuant to doctor's orders.			
Signature:		Date:	