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.

Employee's Personal Information:			
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:

Accident Information:		
Date of Loss:	Time of Loss:	Time workday began:
Date Employer Notified:	Has Employee Returned To Work?: ☐ YES ☐ NO	
Dates off work so far:		
Accident resulted from : ☐ A Single Incident ☐ Cumulative Incidents		
Location of Accident- Address:		
Building:	City:	State:
Did the accident result in the employees death? ☐ YES ☐ NO		Date of death:

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 sheet to explain injury. Attach sheet to explain.	

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

Treatment:			
Initial Treatment: ☐None Required ☐ Refused ☐ First Aid ☐ Physician or Clinic ☐ Emergency Room			
Was follow up medical treatment required after initial treatment: ☐ YES ☐ NO			
Did the employee return to work following medical treatment? ☐ YES ☐ NO. If NO, Estimated time off work?			
Treating Physician / Hospital - Name:			
Address:	City	State:	Zip:

Supervisor's Information:		
Name:	Did you Witness The Incident? ☐ YES ☐ 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.		

Certification:	
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: **EMAIL**: jackie-lartey@ouhsc.edu FAX: 405-271-3925 Campus mail: 865 Research Pkwy, Ste 270 attn: Work Comp
NORMAN: Return forms: **EMAIL**: carrieclark@ou.edu FAX: 405-325-2435 Campus mail: NEL Room #112 attn: Work Comp
TULSA: : Return forms: **EMAIL**: taylor-garrett@ouhsc.edu FAX: 918-660-3200 Campus mail: 1C114 attn: Work Comp