EMPLOYEE'S INSTRUCTIONS & RESPONSIBILITIES FOR ON-THE-JOB INJURY/ILLNESS

Risk Management

Responsibility of the Employee and Instructions

All employees are required to report every work-related on-the-job injury or illness to his or her supervisor immediately. Failure to promptly report a job-related injury is considered grounds for termination. Once the report is completed, the employee is required to submit it to the supervisor. The supervisor will forward all documentation to Risk Management.

***Note: If the employee is seriously injured or ill, contact EMSA. This form can be completed at a later time.

Once the report is received by Risk Management, there will be follow-up call to the employee for purposes of further investigation and directing care, if necessary. An insurance claim may be filed with the insurance carrier. If so, the insurance carrier will follow-up with the employee promptly.

Should an employee seek medical attention, he or she is required to immediately provide documentation to the supervisor and Risk Management regarding his or her ability to work. If the employee is unable to personally deliver the treating physician's status report, it can be faxed to Attn: Risk Management (918)495-7563 or mailed to Attn: Risk Management, Oral Roberts University 7777 South Lewis Avenue Tulsa OK 74171.

Employees placed on "no work" status ***MUST*** keep Risk Management and the immediate supervisor informed of absences, doctor's appointments and medical progress *that must be accompanied by documentation from the treating physician*. *Employee's returning to work from a "no work" status must provide documentation from the treating physician regarding his or her ability to return to work*. Should you have any further questions, please contact Risk Management at (918)495-7560.

All documentation should be forwarded to Risk Management.

ORU | MAKE NO LITTLE PLANS HERE

EMPLOYEE'S REPORT OF ON-THE-JOB INJURY/ILLNESS

Risk Management

To be completed by the Employee only. Provide full details. Use ink only.

EMPLOYEE'S INFORMATION

Date Report Completed: ____/____/____

Employee's Legal Name: _____

Title: _____ Department Name: _____

Home Phone #: _____ Department Phone #: _____

Department Fax #: _____ Email: _____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Workdays (i.e. Mon – Fri): _____ Schedule (i.e. 8am – 5pm): _____ No. Hours Worked/Week: _____

Hourly Wage: _____ Weekly Salary: _____ Date of Hire: _____

Z#: _____

DESCRIPTION OF TIME AND LOCATION

Were you Performing Regular Job Duties? ☐Yes ☐No If yes, describe the assigned task you were performing at the time of the incident. _____

Time you Reported to Work? ____ ☐ a.m. ☐ p.m. Date & Time of Incident: ____/____/____ ☐ a.m. ☐ p.m.

Location of the accident: _____
Address Area (loading dock, bathroom, etc.)

Last Day Worked? : ____/____/____

DESCRIPTION OF INJURY OR ILLNESS

Describe fully how the accident occurred (including events that occurred immediately before the accident). _____

_____

_____

_____

What part(s) of your body was/were injured? What was the nature of the injury (i.e. bruise to left knee, cut to right index finger)? *BE VERY SPECIFIC*. _____

_____

When did you report the accident to your supervisor? (Please provide date & time): ____/____/____ a.m. / p.m.

Type of Treatment Received: ☐First Aid ☐Medical ☐None

If *First Aid*, describe. _____

If *Medical*, provide date first treated & name and address of treating physician or hospital. _____

_____

If *No Treatment* was received at the time of the injury, will you require medical attention? ☐Yes ☐No ☐Maybe

ADDITIONAL INFORMATION

Recommendation on how to prevent this accident from recurring: _____

_____

Name of Supervisor _____ Phone # _____

Please list any witnesses to the incident.

Name: _____ Title: _____ Phone: _____

Name: _____ Title: _____ Phone: _____

Name: _____ Title: _____ Phone: _____

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. Any person who commits Workers' Compensation fraud, upon conviction, shall be guilty of a felony.

Employee Signature: _____ Date: _____

Retain a copy of this Report and give the original to your Supervisor.

Completed by Risk Management Office Only

Claim No. _____ Adjuster Name _____ Contact Info _____

Rev. 4.3.14