HOW TO REPORT WORK RELATED INJURIES

CLAIMS ARE MOST EFFECTIVELY RESOLVED WHEN REPORTED WITHIN 24 HOURS OF THE EMPLOYEE'S REPORT OF INJURY.

STEP 1

Once an injury has occurred, our first priority is to obtain appropriate medical care for the employee as needed. Medical care must be offered as soon as possible; however, and employee has the right to refuse treatment. (If the employee refuses medical treatment, ensure that they note that in the appropriate spot on the incident report.) At the discretion of the department, the employee may be sent for drug testing, even when treatment is declined. In cases where there has been damage to University property, drug testing is mandatory. Contact Human Resources for guidance.

NOTE: Employees should be advised that any bills related to their on-the-job injury received at their home should be brought to HR for submission to our third party administrator, Consolidated Benefits Resources (CBR).

STEP 2

Complete claim forms (available on the HR webpage) and submit to HR within 24 hours of the accident.

CLAIM FORMS TO BE UTILIZED WHEN AN INJURY OCCURS

ALL INJURIES

Report of Occupational Injury or Illness

To be completed by the employee **and** the supervisor/manager on the day the injury occurs. If the injury results in the need for immediate medical attention, please have the employee complete this form when physically capable and then forward to HR. (This form should be used to document an incident regardless of whether medical treatment is required.)

INJURIES WHERE MEDICAL TREATMENT IS PROVIDED:

Medical Care Authorization Form.

This form is used when the injured worker needs medical treatment away from the work site. Please complete the top portion and send the form with the injured worker to the medical provider. The medical provider should complete the lower portion of the form and return it to the employee or send to HR.

Injured Worker First Fill Prescription Form.

This form may be completed by HR and sent with the worker when they go to the doctor. This provides authorization to dispense up to a 10-day supply of medications if prescribed by the workers' compensation doctor.

Witness/Co-Worker Statement.

This form should be completed by the person that witnessed the injury. This form is most useful on serious injuries as it documents who witnessed the incident or was involved in the incident.

Consent Authorization for Disclosure of Protected Health Information

This form speeds up payment of medical bills and is required to obtain medical records.

Medicare SSDI Questionnaire

All injured employees should complete and sign.

Sick/Annual Leave Election Form

This form allows the opportunity for the injured worker to supplement their workers' compensation benefits by using a pro-rated portion of their accrued sick/annual leave time.

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Occupational Injury or Illness Report

This form contains sections to be completed by both the supervisor and the employee.

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Supervisor Section

Date of Injury:		Date Reported:		Employer Name:	
Name of Employee:			S.S. No:	XXX-XX-	(last four digits)
Home Address, City, Zip Code:					
Home Phone:		Work Ext:		Date of Birth:	
Cell Phone:					
Sex:	Occupational Title:			Date of Employment:	
Time Work Shift Began: AM/PM		Time Accident Occurred: AM/PM		Day of week M T W TH F S SU	
Location:					

Injury Type (Circle)

25	Foreign Body in Eye	**81**	Animal, Insect, Human Bite	**28**	Fracture
43	Cut/Puncture	**46**	Hernia/ Rupture	**02**	Amputation
40	Abrasion/Scratches	**99**	Heart Attack/Stroke	**68**	Skin Irritation/ Dermatitis
10	Bruise/Contusion/Crushing	**72**	Hearing Impairment	**07**	Concussion/ Loss of Consciousness
49	Sprain/Strain	**66**	Exposure (Chem. Temp. Elect)	**24**	Death
04	Burn (Chem, Liquid, Electrical)	**81**	Exposure (Blood/ Body Fluid)	**00**	Other

Injury Cause (Circle)

46	Struck by/ Against Object	**31**	Noise	**85**	Animal, Insect, Human
25	Fall-Same Level, Different Level	**98**	Repetitive Motion/Trauma	**84**	Hot Object, Substance or Fire
54	Jumping or Climbing	**30**	Slipping/Tripping	**26**	Caught in/Under/ Between
48	Vehicle Accident/ Struck by Vehicle	**57**	Pushing/Pulling/ Lifting/ Carrying	**59**	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	
If yes, explain:			

Body Part Injured (Circle)

02	Head/Neck/Face/Mouth	**44**	Wrist (Left Right)	**74**	Hips/ Buttocks
05	Eye (Left Right)	**45**	Hand (Left Right)	**46**	Fingers (Left Right) Digit:
04	Ear (Left Right)	**61**	Back (Upper Lower)	**83**	Knee (Left Right)
48	Shoulder (Left Right)	**67**	Chest/Abdomen Including internal organs	**85**	Ankle (Left Right)
41	Arm (Left Right)	**66**	Pelvis/ Groin	**86**	Foot (Left Right)
42	Elbow (Left Right)	**82**	Leg (Thigh Calf)	**87**	Toes (Left Right) Digit:
73	Respiratory	**01**	Other	**96**	No Physical Injury

First Aid or Medical Treatment

Was first aid given?	Yes	No	If yes, by whom:	
Was medical treatment required by a physician or hospital?			Yes	No
Physician/ Hospital Name, Address, and telephone number:				

Employee's Statement	Employer:		Page 2

Explanation of injury (How, When, Where)

Date you first noticed the pain?		Did this pain develop gradually?		Or suddenly?	

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

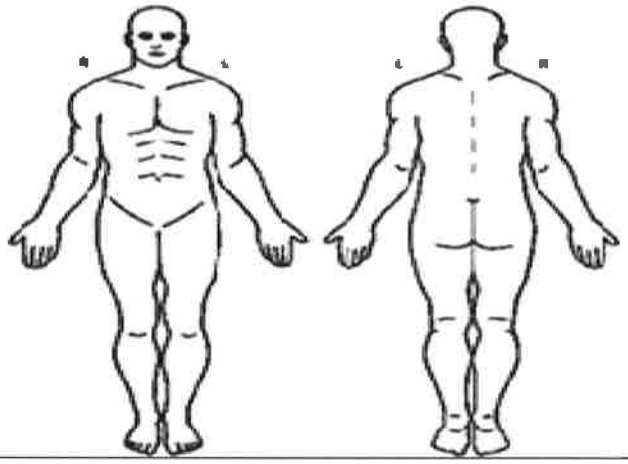
List body parts injured:

Have you discussed this pain with anyone at work? If yes, with whom and when?	Yes	No
Have you had any recent non-work related injuries/illnesses? If yes, please list:	Yes	No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment die you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.
Example: **"A-6= Ache- Severe pain"**



Note type of pain:

A = Ache	**B** =Burning	**P** = Pins & Needles
N = Numbness	**S** = Stabbing	**O** = Other

Note level of pain:

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother you
2	Moderate pain that requires medication to tolerate the pain
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most sever pain, unbearable

Was medical treatment away from the job site offered?
Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	
Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)?	Yes	No	
Are you currently receiving Medicare assistance?	Yes	No	
Do you currently have a Child Support Lien	Yes	No	

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.

Employee Name: (Print)		
Employee Signature:	Date:	

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt?	Yes	No	If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	Address	Phone	Date

Supervisor's Signature:		Date:	

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WITNESS/CO-WORKERS STATEMENT

I, _____ was present at the time that employee
(Witness name)

_____ was reported to have received an on-the-job injury.
(Injured employee)

I did _____ did not _____ witness the injury that occurred.

The following is a brief description of what I observed on _____ at
(Date)

approximately _____ a.m. _____ p.m. _____.
(Time)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

_____

Witness **Date**

_____

EMPLOYER

SEND ORIGINAL TO:

CONSOLIDATED BENEFITS RESOURCES
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*

RETAIN COPY FOR YOUR FILE

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

Consent for Release of Protected Health Information

I, _____(Circle) Patient, Parent, Guardian, legal custodian of:

_____ **SSN: ____ ____ ____ DOB:____ ____ _____**
(NAME OF PATIENT)

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Workers' Compensation Claims
Consolidated Benefits Resources
P.O. Box 581630
Tulsa, Oklahoma 74158-1630

Name of individual/company to disclose PHI:

_____

_____

Information authorized for use or disclosure, or to be obtained:

☐ All medical information concerning this patient.

☐ Medical information of this patient compiled between the dates of _____and _____.

☐ Only:_____

The information will be obtained, used and/or disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐ Workers' Compensation Benefits ☐ Other (specify) _____

Date Authorization expires: _____ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to Claims Manager of Consolidated Benefits Resources.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse confidentiality requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Representative **Date** **Employer**

_____ _____
Representative's Relation to Patient **Employer Address**

_____ _____
Signature of Witness **Date** **Date Authorization expires**

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to order of a court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, or by an order of a court or the Department of Health.

A COPY IS AUTHORIZED AS AN ORIGINAL

Mandatory Medicare Reporting Requirement

******* Please complete this form with each report of injury*******

The Centers for Medicare & Medicaid Services require mandatory reporting of workers' compensation claims. Please complete the following to see if this is an eligible claim to report.

To be completed by the employee (Please print)

Date: _____

Injured Worker Name: _____
(Name as it appears on your social security card)

Social Security Number: **XXX-XX-**_ _ _ _ Date of Birth:_____

Dear Injured Worker, please provide an answer to the following questions:

YES	NO	
☐	☐	**Are you currently on SSDI? (Social Security Disability)**
☐	☐	**Have you ever applied for SSDI?**
☐	☐	**Do you anticipate filing for SSDI within the next 30 months?**
☐	☐	**Are you a Medicare beneficiary?**
☐	☐	**Have you or are you currently participating in a Medicare Advantage Plan?** (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.)
☐	☐	**Do you anticipate filing for Medicare benefits in the next 30 month?**

_____

Signature of Injured Worker Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*

SSDIANSWER

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Workers' Compensation-Sick/Annual Accrued Leave Election Form

The Educational Institution shall provide the benefits established under the Administrative Workers' Compensation Act to all educational institution employees who are injured in a on-the-job accidents. All regular employees who are injured in a on-the-job accidents shall receive statutory benefits including medical expenses, temporary compensation and benefits for permanent disability or death and are allowed to make an election to supplement their temporary compensation.

I suffered an on-the-job injury on (month, day, year)_____ , while working for the educational institution. As a result of the injury, I acknowledge that I am entitled to receive temporary disability compensation according to the Administrative Workers' Compensation Act of Oklahoma. I further understand that I am entitled to receive such compensation for a period of time as may be provided for by law. I have accumulated certain sick leave/personal leave benefits, because of my employment, which are available to me when I am unable to work because of illness or injury.

Place an "X" in the appropriate option(s) below

Mark One: ☐ Certified ☐ Support Personnel

1. ☐ I am electing to have my workers' compensation benefits supplemented by deducting a pro-rated portion from my accrued sick/personal leave time.

   Number of days (To be filled in by a Human Resources representative)

   I understand that by choosing to be paid my accrued sick leave/personal leave in addition to the temporary disability provided by law, I will be paid my sick leave/personal leave on a pro-rated basis to the extent that I will receive my full wages until I return to work or the number of sick leave/personal leave days I have are exhausted. I understand that after the number of specified sick leave/personal leave days are exhausted, I will receive temporary disability compensation for a period of time as may be provided for by law. I understand that my accrued sick leave/personal leave benefits will be decreased on a prorated basis by those days I use as a result of making this election.

2. ☐ I am electing to be paid for the waiting period by deducting ____days from my sick/personal accrued leave time.

   Under the Administrative Workers' Compensation Act, temporary benefits begin the fourth day off work due to an on-the-job injury. The first three calendar days are considered a waiting period during which time temporary benefits are not paid, but I request that I be paid my accrued but unused sick leave/personal leave to cover ___days.

   (Note: if you are electing to be paid a supplement to your weekly workers' compensation benefits; and also to be paid for the waiting period, you must mark your election to both numbers 1 & 2.)

3. ☐ I do not authorize the use any of my accrued sick leave/personal leave benefits while I am off work due to my on-the-job injury. I will be paid only the Workers' Compensation benefits allowed by law.

Name _____ Social Security # _____
Last First Middle

Address _____
Number and Street City State Zip Code

Institution: _____ Department_____ Job Title_____

_____
Signature of Employee Date

Witness:_____
Institution Representative

NORTHEASTERN STATE UNIVERSITY

Information for Injured Employee

All employees have a primary responsibility for the safety and well-being of the campus community. Despite all efforts to promote safety, accidents do occur. When they involve personal injury to an employee, specific procedures must be followed to ensure prompt treatment as needed for the injured employee and effective follow-up to the event. The cause(s) of an accident must be investigated and steps taken to prevent reoccurrence.

On-the-job injuries are governed by the State of Oklahoma Workers' Compensation Act. An employee injured on the job to any extent should report immediately to his/her supervisor. In the absence of the supervisor, the injured employee should report to the department designee.

Employees may contact the Human Resources Office for information concerning their rights and obligations. In order to receive workers' compensation payment, an injured employee must be put off work by the physician/provider of record, have a compensable claim and be unable to work for more than three calendar days.

An injured worker has an obligation to assist in personal recovery from a work-related injury or illness. To help make this happen, the worker should:

- *Keep in touch with the University (Office of Human Resources and departmental supervision);*
- *Keep all appointments with assigned doctor(s) and maintain contact with CBR (Consolidated Benefit Resources,* 1-800/826-0419*);*
- *Follow all doctors' instructions and treatment plan;*
- *Cooperate with those who are helping in the return to work process; and*
- *Contact the respective department management and the Office of Human Resources immediately when notified of release to return to work.*

If an employee misses work because of a medically documented on-the-job injury, he/she has the option of augmenting workers' compensation benefits and must authorize the use of earned leave for the assigned waiting period and any other time missed due to injury. A Leave Election Form must be completed by the employee to advise the University regarding leave use.

The employee is to submit a medically documented "Return to Work" report in order to resume work. The form includes a section for restrictions and limitations imposed by the treating medical professional.

In some cases, employees may be required to attend safety training as a condition of return to work. It is the employee's responsibility to keep his/her supervisor and the Office of Human Resources informed of progress and anticipated date of return to work. Limited or light duty options are determined by departmental supervisors and may be made on a case-by-case basis.

The goal of Workers' Compensation is to achieve a level of recovery that will allow the injured employee to return to work as quickly as possible. Questions concerning Workers' Compensation should be directed to the Office of Human Resources, 918/444-2230.