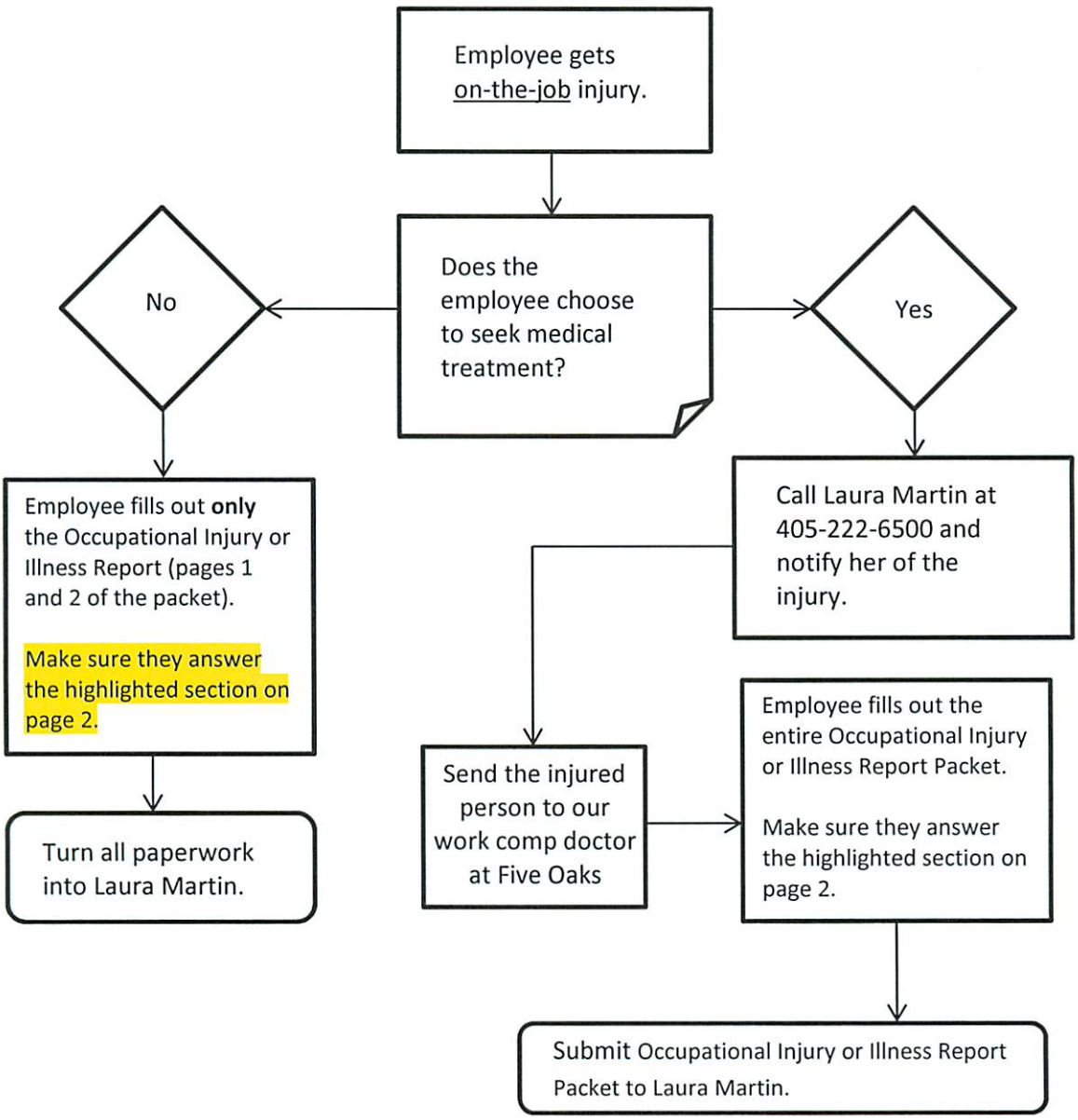
WORK-RELATED INJURY



Contact Laura Martin with any questions. If Laura isn't available, direct questions to Michelle Fleetwood.
405-222-6500

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:		
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: | Date?

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?

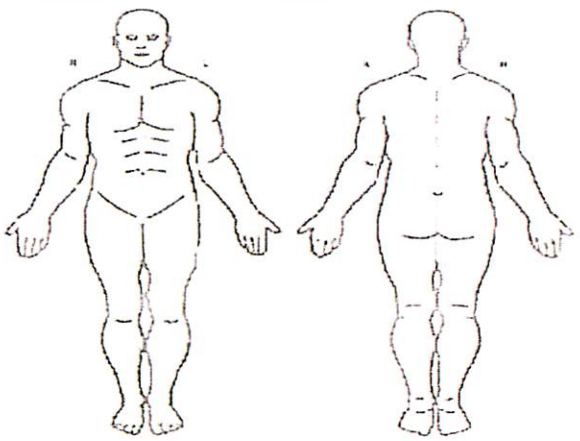
List body parts injured:

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	

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:	

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The School District shall provide the benefits established under the Workers' Compensation Code to all School District employees who are injured in on-the-job accidents. All regular employees who are injured in 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 School District. As a result of the injury, I acknowledge that I am entitled to receive temporary disability compensation according to the Workers' Compensation Code 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 of wages from my sick/personal accrued leave time.

   Under the Workers' Compensation Code, temporary benefits begin the eighth day off work due to an on-the-job injury. The first seven 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 these ____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

School District: _____ Department_____ Job Title_____

_____ _____
Signature of Employee Date

Witness:_____
School District Representative

Mandatory Medicare Reporting Requirement

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

Medicare now requires mandatory reporting of Workers' Compensation claims. The purpose of the reporting process is to enable Centers for Medicare & Medicaid Services (CMS) to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer.

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-_ _ _ _

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

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

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