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: Ponca City Public Schools
Name of Employee:		S.S. No:		
Home Address:				
Home Phone:		Work Ext:		Date of Birth:
Cell Phone:				
Sex:	Occupational Title:		District Hire Date:	
Time Work Shift Began: AM/PM		Time Accident Occurred: AM/PM		Day of week M T W TH F S SU
Location of Accident:				

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

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:

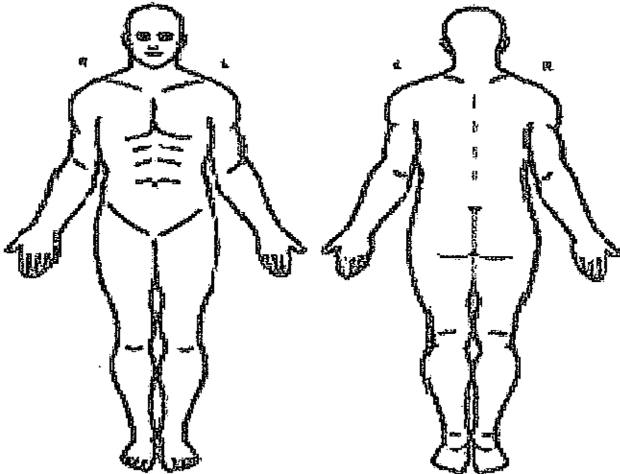
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

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 did 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	

It is the policy of this School District that a post-accident drug and alcohol test be performed on all reported accidents by the first health care provider. The result of said test shall be admissible as evidence in any future legal proceedings related to the on the job accident per O.S. Title 85.

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:**	

OSAG

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?
		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, L.L.C.
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*

Consent for Release of Protected Health Information OSAG

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, LLC.
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, LLC.
- 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**

Ponca City Public Schools
Employer

____
Representative's Relation to Patient

111 W. Grand Ave., Ponca City, OK 74601
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

OSAG

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)

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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, L.L.C.
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.