HUMAN RESOURCES
The UNIVERSITY *of* OKLAHOMA
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Notice to Injured Employees

In order to file a Workers Compensation claim, you will need to review and complete the forms included in this packet. These forms must be sent to Human Resources, Workers Compensation for claim filing. If you choose to complete these forms by hand, please ensure all writing is legible. Forms may be submitted via email to ouworkerscomp@ou.edu.

*If you need to seek medical treatment, please complete the
Treatment Authorization Form
and provide the form during check-in at the treatment facility.

*If you do not need medical treatment, please complete the
Medical Treatment Waiver Form.

**Please be advised that completing and submitting your forms does not guarantee your injury/illness claim is accepted by Workers Comp insurance. An adjuster will contact you regarding the claim's acceptance or denial.

University of Oklahoma Supervisor's Report of Injury*- To be completed by the supervisor and/or equivalent 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 give a copy to your supervisor. *Injury includes exposure and/or illness.

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:

Injury Information:		
Date of Injury:	Time of Injury:	Time workday began:
Date Supervisor Notified:	Has employee returned to work? ☐ YES ☐ NO	
Dates off work:		
Injury resulted from: ☐ A Single Incident ☐ Cumulative Incidents		
Location of Incident - Address:		
Building:	City:	State:
Did the injury result in the employee's death? ☐ YES ☐ NO		Date of death:
Injury Details:		
Work activity when injury occurred:		
Object of substance causing injury:		
Type of Injury:	If SHARPS EXPOSURE, identify type/brand of object below:	
Body Part(s) involved in injury: ☐ Left ☐ Right		
Treatment:		
Initial Treatment: ☐ None Required ☐ Refused ☐ First Aid ☐ Authorized Physician or Clinic ☐ Emergency Room		
Follow up medical treatment required:		
Did employee return to work following medical treatment?		
Treating Physician / Clinic Name:		

Address:	City:	State:	Zip:

Supervisor's Information:		
Name:	Did you witness the incident? ☐ YES ☐ NO	
Title:	Phone:	Email:
What actions were taken or could have been taken to prevent this type of incident?		

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:

Submit all documents to ouworkerscomp@ou.edu

Please include any documentation received from treating physician/clinic.

University of Oklahoma Employee's Report of Injury*- To be completed by the employee 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 give a copy to your supervisor. *Injury includes exposure and/or illness.

Personal Information:			
Last Name:	First Name:		Middle Name:
Home Address: Street:			
City:	State:	Zip:	Personal Phone:
Date of Birth:	SSN:		Employee ID:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Sex: ☐ Male ☐ Female	
OU Department:	Work Phone:		
Injury Information:			
Date of Injury:	Time of Injury:	Time workday began:	
Dates off work:			
Injury resulted from: ☐ A Single Incident ☐ Cumulative Incidents			
Location of Incident - Address:			
Building:	City:	State:	
Injury Details:			
Work activity when injury occurred:			
Body parts involved in injury: ☐ Left ☐ Right		Type of injury:	
Object or substance causing injury or exposure:			
If SHARPS EXPOSURE, Identify type and brand of object:			
If injury involves an animal (bite, puncture, exposure), provide the IACUC protocol number on which the animals are used:			
How did the injury occur? (attach additional sheet if needed):			
Other persons present when the injury occurred: (attach additional sheet if needed)			
Name:	Phone:	Employer:	
Treatment:			
Initial Treatment: ☐None ☐ First Aid ☐ Physician or Clinic ☐ Emergency Room			
Was follow up medical treatment required after initial treatment: ☐ YES ☐ NO			
Treating Physician/Clinic or Hospital - Full Name:			
Address:	City:	State:	Zip:

Certification and Authorization:	
I hereby declare that I have examined this report of my injury and to the best of my knowledge and belief the information I have supplied is true, correct and complete. I understand that any employee who falsifies this report and commits any other Worker' Compensation fraud is subject to criminal penalties and University disciplinary proceedings up to and including termination. Under the Workers' Compensation Act, and injured employee of the University of Oklahoma who received temporary total disability benefits under the Act shall have the option to supplement temporary total disability benefits with any leave accrual available to the injured employee to the extent that the injured employee shall receive full wages. I hereby declare that I have read and understand my option to supplement any temporary total disability benefits under the Workers' Compensation Act.	
Signature:	Date:

Submit all documents to ouworkerscomp@ou.edu

Please include any documentation received from treating physician/clinic.

Authorization to Release Shared Protected Health Information

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ Phone: _____

I authorize _____ (my treating doctor or the treating facility full name) to share my entire medical record covering all services for reasons permitted by law.

Person/Organization Authorized to Receive my Information:

A. The University of Oklahoma, Human Resources, Workers Compensation Analyst, All Campuses
B. Christensen Law Group, 3401 N.W. 63rd Street, Suit. 600, Oklahoma City, OK 73116, Employer Legal Representative and/or
C. Bonham & Howard, 3555 N.W. 58th Street, #1000, Oklahoma City, OK 73112, Employer Legal Representative and/or
D. CCMSI, 1501 North University, Suite 767, Little Rock, AR 72207, Employer Workers' Compensation Third-Party Administrator.

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address listed in "A" above. I understand my revocation will not apply to information already retained, used, or disclosed in response to 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.
- A photocopy or facsimile of this Authorization shall be as valid as the original.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy regulations.
- I understand this Authorization also authorizes the release of any all medical records from any and all medical providers.
- I also authorize the production of my medical records before any Court of competent jurisdiction.
- My medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
- My medical information may indicate that I have, or have been treated for, psychological or psychiatric conditions or substance abuse.
- This Authorization will automatically expire in twelve (12) months of the date of the signature below.

_____ **Date**: _____

Employee Signature

(updated August 2024)

The UNIVERSITY of OKLAHOMA

Workers' Compensation Treatment Authorization Form

Dear Medical Provider:

Please be advised the following employee is authorized to receive initial care for an injury or illness the employee reports having received on-the-job for the University of Oklahoma. The incident will be investigated. This authorization is not an admission of liability or compensability under the Oklahoma Workers' Compensation Act.

Today's Date: _____

Employee: _____ Campus: _____

Department: _____ Title: _____

Date of injury: _____ Time of injury: _____

Nature of injury: _____ Body part(s): (L) (R) _____

Authorized by: (please print) _____
Immediate Supervisor or Departmental Manager

Phone Number: _____

Signature: _____

It is the philosophy of the University of Oklahoma to provide modified duty when possible.

Please forward medical treatment reports and/or invoices to OU's Workers' Compensation Administrator, effective July 1, 2006:

Cannon Cochran Management Services, Inc.
1501 North University, Suite 552
Little Rock, AR 72207
Phone: 800-871-5964 (toll-free)
Fax: 501-280-0950

If you have any questions, please contact Workers Comp at ouworkerscomp@ou.edu

Revised August 2024

The UNIVERSITY of OKLAHOMA

Medical Treatment Waiver

I acknowledge that the University of Oklahoma has offered medical treatment for the _____ injury I claim to have sustained on-the job on _____.

I decline to seek a medical evaluation of my injury at this time.

I agree to notify the Department of Human Resources, before treatment is sought, if I believe my situation changes and treatment is needed.

Employee Name Printed: _____

Employee Signature: _____

Date Signed: _____

Supervisor Signature: _____

Date Signed: _____

Return form to: Department of Human Resources
EMAIL: ouworkerscomp@ou.edu
Attn: Workers Compensation