ODAFF
Employee Injury Reporting Procedures

Human Resource Department
2800 N. Lincoln Blvd
Oklahoma City, OK 73105
(405)522-5777
1. Network Provider information listed by county.
2. Workers Compensation Incident Investigation Report Form
   2.1.1. Employee or Supervisor will complete, p. 1.
   2.1.2. Supervisor will complete the investigation, p. 2.
   3.1.1. Employee will complete date and sign.
   3.1.2. Risk Management Coordinator will date and sign.
   4.1.1. Employee will complete, date and sign.
   4.1.2. Supervisor will review, date and sign.
   5.1.1. Employee will complete date and sign.
7. ODAFF WC Program Leave Option Election Work Related Accident /Illness
   7.1.1. Complete and return to HR with WC package. (if you are absent from work because of WC)
8. OPERS Application for Purchase of Delinquent Service. (OPERS Enrollment ONLY) Does not apply to Pathfinder Retirement.
   8.1.1. If employee elects to purchase the delinquent service time, it is the employees’ responsibility to submit the request to HR.
9. ODOL 300 Questionnaire.
   10.1 Employee will complete.
10. Employee will forward Return to Work Status form; returned to HR after each medical visit.
   11.1 Medical provider will complete, date and sign.
   11.2 Employee forwards to Supervisor.
   11.3 Supervisor forwards to Human Resource Department.

*The claim cannot be submitted to Gallagher Bassett until HR receives the completed Workers Compensation Forms listed below; from the injured employee and supervisor.*
Table of Contents & Instructions

Return the below forms to the Human Resource Department as soon as possible and no later than 3 working days.

1. Workers Compensation Incident Investigation Report Form.
5. ODAFF Leave Option Election Work Related Accident/Illness
6. OPERS Application for Purchase of Delinquent Service
7. ODOL 300 Questionnaire.
8. Return to Work Status form; returned to HR after each medical visit

After your claim has been submitted to Gallagher Bassett you will be assigned one of the below claims adjusters within approximately 5 working days. If you have any question or concerns regarding your claim please contact your assigned adjuster.

Trent Voth                      405-415-8304      Trent_Voth@gbtpa.com
Kathy Wigley                    405-415-8309      Mary_Wigley@gbtpa.com
Twana Brinlee                   405-415-8308      Twana_Brinlee@gbtpa.com
Michael Baxter                  405-415-8307      Michael_Baxter@gbtpa.com
Elaine Howard                   405-415-8311      Elaine_Howard@gbtpa.com
Bradley Morrisett              405-415-8305      Bradley_Morrisett@gbtpa.com

PeopleSoft Workers Compensation Leave Codes
WCANP – Workers Comp An Lv Hrs Pd
WCCT1 – Workers Comp Comp Time Hrs Pd
WCSKP  – Workers Comp Sick Lv Hrs Pd
WCWOH– Workers Comp Without Pay Hours

If you receive a bill in the mail, make a copy and mail original to:
Gallagher Bassett Services, Inc.
PO Box 2831
Clinton, IA 52733-2831
<table>
<thead>
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<th>Location</th>
<th>Name</th>
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<th>City</th>
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<tr>
<td>Canadian County</td>
<td>Urgent Care Travel</td>
<td>Urgent Care Clinic</td>
<td>406 S Morgan Rd</td>
<td>Oklahoma City</td>
<td>OK 73128</td>
<td>405-789-0212</td>
<td>405-789-0243</td>
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<td>Canadian County</td>
<td>Access Medical Center</td>
<td>Urgent Care Clinic</td>
<td>301 S Mustang Rd</td>
<td>Yukon</td>
<td>OK 73099</td>
<td>405-324-1911</td>
<td>405-265-4078</td>
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<td>Family Health Care &amp; Minor Emergency Clinic Inc</td>
<td>Urgent Care Clinic</td>
<td>11109 Surrey Hills Blvd</td>
<td>Yukon</td>
<td>OK 73099</td>
<td>405-373-2400</td>
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<td>Jordan, James L., MD</td>
<td>Occupational Medicine</td>
<td>520 S Mustang Rd</td>
<td>Yukon</td>
<td>OK 73099</td>
<td>405-936-5910</td>
<td>405-577-2605</td>
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<td>Carter County</td>
<td>Mercy Occupational Medicine</td>
<td>Occupational Medicine Clinic</td>
<td>921 14th Ave NW</td>
<td>Ardmore</td>
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<td>580-223-5311</td>
<td>580-223-2397</td>
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<td>Carter County</td>
<td>Urgent Care of Ardmore</td>
<td>Urgent Care Clinic</td>
<td>908 N Rockford Ste A</td>
<td>Ardmore</td>
<td>OK 73401</td>
<td>580-226-7771</td>
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<td>Choctaw County</td>
<td>Hugo Medical Clinic</td>
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<td>1201 East Jackson St</td>
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<td>OK 74743</td>
<td>580-326-6423</td>
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<td>Cleveland County</td>
<td>Mercy GoHealth Urgent Care-Moore</td>
<td>Urgent Care Clinic</td>
<td>705 SW 19th St Ste 120</td>
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<td>OK 73160</td>
<td>405-492-6799</td>
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<td>Classen Urgent Care Clinic LLC</td>
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<td>1025 SW 4th St Ste 101</td>
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<td>Quest Pediatric Therapy PLLC</td>
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<td>400 N Eastern Ave</td>
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<td>405-601-4303</td>
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Cleveland County
Quick Urgent Care LLC
Urgent Care Clinic
2212 N Broadway St
Moore OK 73160
Office: 405-285-7222 Fax: 405-285-7227

Cleveland County
Access Medical Center
Urgent Care Clinic
334 12th Ave SE Ste 110
Norman OK 73071
Office: 405-321-1911 Fax: 405-321-1610

Cleveland County
Immediate Care of Oklahoma LLC
Urgent Care Clinic
3400 W Tecumseh Rd Ste 100
Norman OK 73072
Office: 405-307-6900 Fax: 405-307-6906

Cleveland County
Access Medical Center
Urgent Care Clinic
11601 S Western Ave
Oklahoma City OK 73170
Office: 405-691-5208 Fax: 405-378-0056

Cleveland County
Mercy Gohealth Urgent Care Moore
Urgent Care Clinic
705 SW 19th St Ste 120
Oklahoma City OK 73160
Office: 405-492-6799 Fax: 405-595-0579

Comanche County
WellFast Urgent Care Center
Urgent Care Clinic
1902 E Gore Blvd
Lawton OK 73501
Office: 580-357-4200 Fax: 580-357-4201

Garfield County
Radiology Corp of America Imaging Services Inc
Urgent Care Clinic
305 S 5th St
Enid OK 73701
Office: 866-293-3500 Fax:
**Grady County**
Healthcare Stat LLC
Urgent Care Clinic
1928 S 4th St
Chickasha OK 73018
Office: 405-224-6700 Fax: 405-224-6707

**Harmon County**
Shortgrass Community Health Center
Urgent Care Clinic
400 E Sycamore St
Hollis OK 73550
Office: 580-688-2800 Fax: 580-688-2193

**Hughes County**
East Central Oklahoma Family Health Center
Urgent Care Clinic
109 S Main St
Wetumka OK 74883
Office: 405-452-5400 Fax: 405-452-3000

**Hughes County**
Wetumka Indian Health Center
Urgent Care Clinic
325 S Washita St
Wetumka OK 74883
Office: 405-452-1300 Fax: 405-452-3802

**Jefferson County**
Family Clinic Of Ringling
Urgent Care Clinic
502 S 6th St
Ringling OK 73456
Office: 580-662-2316 Fax: 580-662-2113

**Jefferson County**
Ryan Health Clinic
Urgent Care Clinic
1104 6th St
Ryan OK 73565
Office: 580-757-2451 Fax: 580-757-2650

**Kay County**
Urgent Care and Family Practice Clinic
Urgent Care Clinic
1715 N 5th St
Ponca City OK 74601
Office: 580-762-9292 Fax: 580-762-1660

**Kay County**
Family Clinic Of Ringling
Urgent Care Clinic
502 S 6th St
Ringling OK 73456
Office: 580-452-5400 Fax: 580-452-3000

**Le Flore County**
Family Medical Clinic
Medical Clinic
104 Wall Street
Poteau OK 74953
Office: 918-647-8365 Fax:

**Love County**
Love County Rural Health Clinic
Urgent Care Clinic
300 Wanda St
Marietta OK 73448
Office: 580-276-3347 Fax:

**Mayes County**
Dr. Mitchell Collier
Medical Office
609 East Main
Locust Grove OK 74352
Office: 918-479-8060 Fax:

**Mcclain County**
Access Medical Center Pryor
Urgent Care Clinic
4115 Redden
Pryor OK 74361
Office: 918-825-7555 Fax: 918-825-7556

**Mcclain County**
Access Medical Center
Urgent Care Clinic
1000 NW 32nd St
Newcastle OK 73065
Office: 405-387-9325 Fax: 405-387-9355

**Mayes County**
Access Medical Center Pryor
Urgent Care Clinic
4115 Redden
Pryor OK 74361
Office: 918-825-7555 Fax: 918-825-7556

**McCurtian County**
Hochatown Medical Clinic - Urgent Care
Urgent Care Clinic
8901 North Hwy 259
Broken Bow OK 74728
Office: 580-494-6562 Fax:
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Oklahoma County
Mercy Gohealth Urgent Care Oak Grove
Urgent Care Clinic
12200 N MacArthur Blvd Ste D
Oklahoma City OK 73162
Office: 405-437-1100 Fax: 405-492-6789

Oklahoma County
Oklahoma Allergy and Asthma Clinic
Urgent Care Clinic
750 NE 13th St
Oklahoma City OK 73104
Office: 985-893-5780 Fax:

Oklahoma County
Southwest Ambulatory Surgery Center
Urgent Care Clinic
8125 S Walker Ave
Oklahoma City OK 73139
Office: 405-631-1014 Fax: 405-631-1050

Okmulgee County
East Central Oklahoma Family Health Center
Urgent Care Clinic
1102 W Main St
Henryetta OK 74437
Office: 405-452-5400 Fax: 918-652-4831

Okmulgee County
Muscogee Creek Nation Community Clinic
Urgent Care Clinic
1201 S Belmont Ave Ste 207
Okmulgee OK 74447
Office: 918-756-9266 or 918-758-0555 Fax: 918-752-0976, 9

Osage County
Access Medical Center Skiatook
Urgent Care Clinic
2254 W Rogers Blvd
Skiatook OK 74070
Office: 918-895-9353 Fax: 918-895-9354

Pittsburg County
McAlester Regional Health Center Working Well
Working Wellness
3 Blark Bass Blvd
McAlester OK 74501
Office: 918-421-8166 Fax:

Oklahoma County
Neighborhood Family Clinic & Minor Emergency Services Inc
Urgent Care Clinic
5909 NW Expressway Ste G140
Oklahoma City OK 73132
Office: 405-373-2400 Fax: 405-373-4400

Oklahoma County
Optum Womens and Childrens Health
Urgent Care Clinic
1000 W Wilshire Blvd Ste 372
Oklahoma City OK 73116
Office: 770-767-7800 Fax: 770-767-4614

Oklahoma County
Zawahiri, Mohammed, MD
Occupational Medicine
5501 N Portland Ave
Oklahoma City OK 73112
Office: 405-604-6000 Fax:

Okmulgee County
East Central Oklahoma Family Health Center
Urgent Care Clinic
217 S 5th St
Henryetta OK 74437
Office: 918-652-3676 Fax: 918-652-7612

Okmulgee County
Okmulgee Indian Health Center
Urgent Care Clinic
1313 E 20th St
Okmulgee OK 74447
Office: 918-591-5700 Fax: 918-756-4490

Payne County
Access Medical Center
Urgent Care Clinic
275 S Perkins Rd
Stillwater OK 74074
Office: 405-334-5272 Fax: 405-564-0514

Roger Mills County
Buster Rural Health Clinic
Urgent Care Clinic
101 F K Buster Ave Buster Rural Health Clinic Po Box 490
Cheyenne OK 73628
Office: 508-497-3333 Fax:
Rogers County
Access Medical Center Blue Star
Urgent Care Clinic
401 W Blue Starr Dr
Claremore OK 74017
Office: 918-343-6000 Fax: 918-343-6251

Rogers County
Childrens Medical Center of Claremore
Urgent Care Clinic
129 W Blue Starr Dr
Claremore OK 74017
Office: 918-342-2262 Fax:

Rogers County
Reaction Physical Therapy
Occupational Medicine Clinic
1934 S Highway 66
Claremore OK 74019
Office: 918-283-2527 Fax: 918-283-2569

Texas County
Urgent Care of Guymon
Urgent Care Clinic
400 NE 12th St
Guymon OK 73942
Office: 580-338-2637 Fax: 580-338-2652

Tulsa County
MedNow Urgent Care- Broken Arrow
Urgent Care Clinic
503 S Aspen Ave
Broken Arrow OK 74012
Office: 918-286-6331 Fax: 918-806-6330

Tulsa County
St John Clinic Urgent Care Broken Arrow Elm
Urgent Care Clinic
3315 S Elm Pl
Broken Arrow OK 74012
Office: 918-872-6807 Fax: 918-293-3148

Tulsa County
Medexpress Urgent Care Owasso E 86th St N
Urgent Care Clinic
11760 E 86th St N
Owasso OK 74055
Office: 918-272-2829 Fax: 918-272-2816

Rogers County
St John Urgent Care Clinics Inc
Urgent Care Clinic
1910 S Falcon
Claremore OK 74019
Office: 918-343-6855 Fax: 918-403-6310

Rogers County
Function 1st Therapies
Occupational Medicine Clinic
221 S Florence Ave Ste 150
Claremore OK 74017
Office: 918-341-2020 Fax: 877-455-4440, 9

Rogers County
Saint John Clinic Urgent Care Claremore
Urgent Care Clinic
1910 S Falcon Ave
Claremore OK 74019
Office: 918-343-6855 Fax: 918-403-6310

Tulsa County
Access Medical Center Bixby
Urgent Care Clinic
11717 S Memorial Dr
Bixby OK 74008
Office: 918-369-9555 Fax: 918-369-9556

Tulsa County
Broken Arrow Urgent Care
Urgent Care Clinic
1130 E Lansing St
Broken Arrow OK 74012
Office: 918-258-9990 Fax:

Tulsa County
Access Medical Center Owasso
Urgent Care Clinic
13616 E 103rd St N Ste A
Owasso OK 74055
Office: 918-274-8555 Fax: 918-274-8556

Tulsa County
Reaction Physical Therapy
Occupational Medicine Clinic
10229 E 96th St N Ste 102
Owasso OK 74055
Office: 918-274-8541 Fax: 918-274-8560
Tulsa County
St John Urgent Care Clinic
Urgent Care Clinic
402 W Morrow Rd
Sand Springs OK 74063
Office: 918-245-1119 Fax: 918-245-8883

Tulsa County
Concentra Medical Center
Occupational Medicine Clinic
1541 N Sheridan Rd
Tulsa OK 74115
Office: 918-834-4647 or 918-836-5406 Fax: 918-832-8618

Tulsa County
Access Medical Center 81st
Urgent Care Clinic
10221 E 81st St
Tulsa OK 74133
Office: 855-603-1147 Fax: 918-249-3480

Tulsa County
Access Medical Center Utica
Urgent Care Clinic
1623 S Utica Ave
Tulsa OK 74104
Office: 918-392-5100 Fax: 918-392-5110

Tulsa County
Cody, Jimmy Dean, DO
Urgent Care
7127 S Olympia Ave
Tulsa OK 74132
Office: 918-665-9500 Fax: 918-665-9512

Tulsa County
MedNow Urgent Care- Tulsa Hills
Urgent Care Clinic
7127 S Olympia Ave
Tulsa OK 74132
Office: 918-665-9500 Fax: 918-665-9512

Tulsa County
Pisarik, Paul, MD
Urgent Care
1717 S Utica Ave Ste A
Tulsa OK 74104
Office: 918-748-1300 Fax: 918-748-1303

Tulsa County
Concentra Medical Center
Occupational Medicine Clinic
9515 E 51st St
Tulsa OK 74145
Office: 918-622-7488 Fax: 918-622-7071

Tulsa County
Concentra Medical Center
Occupational Medicine Clinic
5682 W Skelly Dr
Tulsa OK 74107
Office: 918-446-1891 Fax: 918-446-1894

Tulsa County
Access Medical Center Garnett
Urgent Care Clinic
2929 S Garnett Rd
Tulsa OK 74129
Office: 918-665-1520 Fax: 918-663-8434

Tulsa County
Access Medical Center-Riverside
Urgent Care Clinic
9716 Riverside Pkwy Ste 100
Tulsa OK 74137
Office: 918-528-4897 Fax: 918-299-4330

Tulsa County
Green, Russell J., MD
Occupational Medicine
1044 N Sheridan Rd
Tulsa OK 74115
Office: 918-609-1600 Fax: 918-609-1319

Tulsa County
My Doctor Urgent Care
Urgent Care Clinic
7153 S Yale Ave
Tulsa OK 74136
Office: 918-619-9400 Fax: 918-619-9433

Tulsa County
St John Urgent Care Clinics Inc
Urgent Care Clinic
8131 S Memorial Dr Ste 102
Tulsa OK 74133
Office: 918-872-6800 Fax: 918-872-6888
Tulsa County
St John Urgent Care Clinic
Urgent Care Clinic
1717 S Utica Ave Ste A
Tulsa OK 74104
Office: 918-748-1300 Fax: 918-403-6353

Tulsa County
Medexpress Urgent Care Tulsa Yale Ave
Urgent Care Clinic
2140 N Yale Ave
Tulsa OK 74115
Office: 918-712-9342 Fax: 918-712-9386

Tulsa County
PediStat PLLC
Urgent Care Clinic
3354 E 51st St
Tulsa OK 74135
Office: 918-928-7828 Fax: 918-576-6114

Tulsa County
Tulsa Regional Medical Center
Urgent Care Clinic
744 W 9th St
Tulsa OK 74127
Office: 918-587-2561 Fax:

Washington County
St John Clinic Urgent Care Bartlesville
Urgent Care Clinic
3550 E Frank Phillips Blvd
Bartlesville OK 74006
Office: 918-338-3730 Fax: 918-331-1466

Washington County
Gemini After Hours Clinic
Urgent Care Clinic
3450 E Frank Phillips Blvd
Bartlesville OK 74006
Office: 918-338-3730 Fax: 918-331-1091

Tulsa County
Access Medical Center-Brookside
Urgent Care Clinic
1217 E 48th St
Tulsa OK 74105
Office: 918-728-3333 Fax: 918-728-3334

Tulsa County
Oklahoma Cancer Specialists And Research Institute
Occupational Medicine Clinic
12697 E 51st St
Tulsa OK 74146
Office: 918-505-3200 Fax: 918-505-3225

Tulsa County
Tulsa Pain Relief Clinic
Urgent Care Clinic
2000 S Wheeling Ave Ste 600
Tulsa OK 74104
Office: 918-742-7030 Fax: 918-742-9958

Wagoner County
Porter Health Clinic
Urgent Care Clinic
505 S Main St
Porter OK 74454
Office: 918-483-0111 Fax: 918-483-0112

Washington County
Access Medical Center
Urgent Care Clinic
2334 SE Washington Blvd Ste B
Bartlesville OK 74006
Office: 918-331-9184 Fax: 918-331-9187

Washington County
Saint John Urgent Care Clinic Bartlesville
Urgent Care Clinic
3550 E Frank Phillips Blvd
Bartlesville OK 74006
Office: 918-338-3730 Fax: 918-331-1466
State of Oklahoma

WORKERS’ COMPENSATION INCIDENT INVESTIGATION REPORT

Check Box: □ INJURY □ ILLNESS □ NEAR MISS

Email completed form to: tnwclaims@tnwinc.com or fax to: 800-748-6159

A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

<table>
<thead>
<tr>
<th>EMPLOYEE’S NAME</th>
<th>M/F</th>
<th>DOB</th>
<th>COMPLETE SSN</th>
<th>JOB TITLE/CLASSIFICATION</th>
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<table>
<thead>
<tr>
<th>EMPLOYEE ID NUMBER</th>
<th>FT</th>
<th>Temp</th>
<th>Seasonal</th>
<th>DATE OF INCIDENT</th>
<th>DATE OF HIRE</th>
<th>TIME WORK DAY BEGAN</th>
<th>TIME OF INCIDENT (AM / PM)</th>
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<thead>
<tr>
<th>AGENCY #</th>
<th>DEPT</th>
<th>OVERTIME?</th>
<th>SHIFT?</th>
<th>HAS EMPLOYEE LOST TIME FROM WORK?</th>
<th>HAS EMPLOYEE RETURNED TO WORK?</th>
</tr>
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<tbody>
<tr>
<td>040</td>
<td>040</td>
<td>Y</td>
<td>2</td>
<td>Yes</td>
<td>No</td>
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</tbody>
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<thead>
<tr>
<th>AVERAGE WEEKLY WAGE</th>
<th>AT THE TIME OF THE INCIDENT THE EMPLOYEE WAS:</th>
<th>performing the following task or tasks:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ break ☐ lunch ☐ arriving/leaving work for the day</td>
<td>☐ on break ☐ on lunch ☐ performing the task or tasks:</td>
</tr>
</tbody>
</table>

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<tr>
<th>EMPLOYEE’S HOME ADDRESS</th>
<th>EMPLOYEE’S PHONE #</th>
<th>Home &amp; Cell</th>
<th>EMAIL</th>
<th>SUPERVISOR’S NAME, PHONE # &amp; EMAIL</th>
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B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? ☐ Yes ☐ No Explain:

LOCATION/ADDRESS (where injury occurred): DESCRIBE WHAT HAPPENED:

C. WAS MEDICAL TREATMENT REQUIRED? ☐ Yes ☐ No

1. If yes, what type of treatment and where was it received?
2. Is there a follow up appointment and if so, when is it?
3. Was employee put on restricted duty?
4. Can restricted duty be accommodated?

D. PART OF BODY INVOLVED (be specific: left, right, upper, lower, etc.)

E. TYPE OF INCIDENT

- ☐ Caught on or in
- ☐ Ingestion
- ☐ Inhalation
- ☐ Fall-same level
- ☐ Bitten
- ☐ Overexertion
- ☐ Electrical
- ☐ Chemical – skin
- ☐ Fall-different level
- ☐ Lifting
- ☐ Struck by/against
- ☐ Slip or Trip
- ☐ Explosion
- ☐ Heat/Cold exposure
- ☐ Cut
- ☐ Auto accident
- ☐ Cumulative injury
- ☐ Puncture
- ☐ Other __________

F. WITNESS TO INJURY (attach witness statement to investigation page 2)

<table>
<thead>
<tr>
<th>NAME #1:</th>
<th>PHONE #:</th>
<th>NAME #2:</th>
<th>PHONE #:</th>
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<tbody>
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G. FORM COMPLETED BY:

Print Name & Title

Phone # & Email Address

Date & Time Injury Reported to Agency

a.m./p.m.

a.m./p.m.
H. SUPERVISOR’S INVESTIGATION OF INCIDENT
WHAT HAPPENED? (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)

I. WHY DID IT HAPPEN?
ROOT CAUSE #1:
ROOT CAUSE #2:
ROOT CAUSE #3:

J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS?
What specifically is being done? How are we addressing root causes, behavior, hazards, training?

K. DISCIPLINARY ACTION TAKEN: ☐ YES ☐ NO
Describe:

L. FALL FROM DIFFERENT LEVEL INFORMATION:
Height: Was a ladder involved? Describe:

M. CAUSE OF INCIDENT – UNSAFE ACT: ☐ BY INJURED PERSON -or- ☐ BY OTHER PERSON (NAME):
☐ Failure to warn or signal ☐ Working/reaching moving equipment ☐ Overloading equipment or containers
☐ Making safety devise inoperative ☐ Failure to shut off or lockout ☐ Wearing unsafe attire, jewelry etc.
☐ Not observing where walking or driving ☐ Moving objects too heavy ☐ Disregard instructions
☐ Operating at unsafe speed ☐ Not wearing PPE ☐ Horseplay
☐ Operating without safety device ☐ Operating without authority ☐ Lack of training
☐ Taking unsafe position ☐ Using unsafe tools or equipment ☐ No unsafe act
☐ Negligence ☐ Employee misconduct ☐ Other __________________________

N. CAUSE OF INCIDENT – UNSAFE CONDITION
☐ Hazardous arrangement ☐ Poor Housekeeping ☐ Wet/slippery/icy floor or ground
☐ Insufficient lighting ☐ Unsafe design ☐ Other __________________________
☐ Insufficient guarding ☐ Ergonomic deficiency ☐ Other __________________________
☐ Faulty machine or equipment ☐ Hazardous work method ☐ Other __________________________
☐ Insufficient ventilation ☐ Poor air quality ☐ Other __________________________

O. CAUSE INFORMATION
YES ☐ NO ☐
1. ☐ Did employee doing his/her regularly assigned job? Explain a “no” answer below.
2. ☐ Did you (supervisor) provide proper instruction on how to do the job safely? Explain a “no” answer below.
3. ☐ Was employee doing this job as you had instructed? Explain a “no” answer below.
4. ☐ Was proper equipment provided? Explain a “no” answer below.
5. ☐ Was the employee using the equipment? Using it properly? Explain a “no” answer below.
6. ☐ Have you had similar incidents with this or other equipment in your area? Explain a “yes” answer below.
Additional comments from above:

P. SAFETY INVESTIGATION AND FOLLOW-UP
YES ☐ NO ☐
Was the investigation thorough?
Was corrective action taken?
Did the supervisor make every attempt to help eliminate the unsafe act or hazard?
Did the employee make every attempt to help eliminate the unsafe act of hazard?

Explanation and recommendations:

Q. INVESTIGATION COMPLETED BY:
Print Name & Title Phone # & Email Address Date Completed
State of Oklahoma
Office of Management and Enterprise Services
Division of Capital Assets Management
Risk Management Department

Personal/Bodily Injury
Standard Liability Incident Report
(Non-Vehicle Injury)

DCAM-RISK MGMT P.O. BOX 53364 OKLAHOMA CITY, OKLAHOMA 73152 TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim Form Requested? □ Yes □ No

Incident Date: __________  Time: __________  Date of Agency Notification: __________

Location:

Address/Highway  City  State  County

Describe Incident:

Photos of accident scene and location need to be taken.

Was Employee Aware of Incident? □ Yes □ No

Claimant’s Information:

Claimant’s Name: ____________________________  Phone: (____) - ______
Address: ____________________________  City: ______________  State: ____  Zip Code ________
Email Address: ____________________________

Was the Claimant Injured? □ Yes □ No
Describe: ____________________________

Name of Doctor or Hospital: ____________________________

Agency Information

Agency Name: ____________________________  Agency # ______  Phone: (____) - ______
Type of Employment: □ Full Time  □ Temporary  □ Volunteer  □ Contract
Employee Name: ____________________________  Job Title: ____________________________
Div. or Dept. ____________________________  Address: ____________________________  Phone: (____) - ______

Witnesses:

Name  Address  Phone
__________________________________________  ____________________________  ____________________________
__________________________________________  ____________________________  ____________________________
__________________________________________  ____________________________  ____________________________
__________________________________________  ____________________________  ____________________________

DCAM/RISK MGMT – FORM 001be (07/2013)
### Claim Number

#### Slip and Fall

- Was the person distracted? □ Yes □ No  If so, by what? ________________________________
- How did the person fall? □ Forward □ Backward □ Other ________________________________
- What part(s) of the body was injured? ________________________________
- Was the person a client of the place where the incident occurred? □ Yes □ No
- Was there a transition in walkway surfaces, or any tripping hazards? □ Yes □ No  If so, explain ________________________________
- Was the surface wet, oily, dirty, slippery, etc.? □ Wet □ Oily □ Slippery □ Dirty □ Other _________
- Were danger or caution signs posted? □ Yes □ No  If so, what? ________________________________
- Was weather (rain/snow) a factor in the incident? □ Yes □ No  If so, describe ________________________________
- Was site cleanup needed? (spill, dirt, etc.)? □ Yes □ No  Describe ________________________________
- How long after first notice was incident cleaned up? ________________________________
- Type of footwear worn? □ athletic shoes □ sandals □ high heels □ flats □ other ________________________________
- Type of material of shoe heel? □ rubber □ leather □ synthetic □ other ________________________________
- Did footwear contribute to the fall? □ Yes □ No  Explain ________________________________

#### Machinery Incidents

- Was injury due to machinery? □ Yes □ No  If so, who was operating? ________________________________
- What type of machinery was involved in the incident? ________________________________
- Policy/procedure regarding operation of machinery? □ Yes □ No  Operator trained? □ Yes □ No
- Machinery last service date? ________________________________  Machinery last safety inspection? ________________________________
- Were safety features in place? (guards, chains etc?) □ Yes □ No  Explain ________________________________

#### General Questions

- Type of terrain? (i.e. flat, hilly, grassy gravel?) ________________________________
- Area inspected/cleared of debris and safety hazards? ________________________________
- Did you speak to a witness? □ Yes □ No  If so, what was said? ________________________________
- Was assistance provided? □ Yes □ No  If so, what? by whom? ________________________________
- Was any non-medical personnel called to accident site? □ Yes □ No  If so, who? ________________________________
- Was the incident reported to local authority? □ Yes □ No  If so, provide police report. ________________________________

*Attach additional sheet, if needed*

By signing this form you are attesting the information contained is accurate.

_________________________  __________________________
Employee Signature        Date                          Risk Coordinator Signature  Date

_________________________  __________________________
Employee Name Printed      Coordinator Name Printed
Incident Date ______________  Time ____________  Claim No (DCAM use only): __________________

Employee Name __________________________________________  Job Title: __________________

State Agency Name __________________________________________  Agency Number ______

Division or Dept __________________________________________  Phone ____________

Address __________________________________________  City ____________  State ______  Zip ______

Type of Employment: [ ] Full Time [ ] Temporary [ ] Volunteer [ ] Contract

Who Authorized This Specific Duty? __________________

Was employee aware of incident? [ ] Yes [ ] No  __________________

Please describe in detail what specific duty was being performed at the time of the incident.

________________________________________________________

Employee Signature

Employee Name Printed

Date

Supervisor Signature

Supervisor Name Printed

Date
GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Claim Number:

(Print Name of Patient)

DOB: ___________ SS#: ___________

Information to be released from:

Name of Designated Facility or Provider

Address

City, State, Zip Code Phone Number

Additional facility or provider:

Name of Designated Facility or Provider

Address

City, State, Zip Code Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN:

Name of Designated Recipient

Address

City, State, Zip Code Phone Number

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)

☐ All medical records

☐ Medical Billing

☐ Specific information (Please specify) _____

Purpose for which disclosure is being made:

Processing of an insurance claim.

Date of Loss:
Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial):
  - [ ] Drug/Alcohol abuse /treatment & diagnosis
  - [ ] Sexually Transmitted Disease
  - [ ] HIV/AIDS diagnosis/treatment/testing
  - [ ] Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ______________________________ DATE: ________________
(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”
Welcome to First Script, a pharmacy benefit program designed exclusively for State of Oklahoma, #006405, in partnership with Gallagher Bassett Services, Inc. for your workplace injury.

### Injured Worker

#### No Cost

**STEP 1**
Complete the information requested in the bottom portion below.

**STEP 2**
Call First Script at 1-866-445-7344 to enroll, and receive your required Member ID.

**STEP 3**
Present this form to your pharmacist along with the prescriptions for your work-related injury.

#### No Delay

First Script is available at over 68,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at 1-866-445-7344.

#### Feel Better Faster

Please note that First Script is valid only for medications prescribed to treat your compensable work-related injury. You or your group health insurer, are financially responsible for any other prescriptions. The workers’ compensation carrier will determine the compensability of the claim.

### Pharmacy Instructions

The injured worker’s employer participates in First Script, a pharmacy benefit program administered by ESI/Medco.

Call the First Script Help Desk, 24 hours a day, 7 days a week, at 1-866-445-7344. If the Member ID number is not listed on this form, please provide the claimant information indicated below to receive the Member ID #. Please note the ID number on the form and return to injured worker. First Script claims are submitted electronically and electronic approval of the claim will be returned.

**Pharmacy:** You will not be required to submit any paperwork for this claim and payment is guaranteed for all electronically accepted claims.

### Pharmacy:

At the request of the workers’ compensation carrier for this customer, please use the following information to process all workers’ compensation prescriptions online.

Name: ________________________________

SSN (Last 4 digits): XXX-XX-________

Date of birth: _____/_____/_____

State where injury occurred: ___________________

Date of injury: _____/_____/_____

Member ID: ________________________________

(Member ID # is generated at time of enrollment)

RX PROGRAM ADMINISTERED BY: ESI/Medco
GROUP NUMBER: FSNCVTY
BIN NUMBER: 610014
Client #: 006405
Employer Name: State of Oklahoma
Employee Information Form
Workers’ Compensation Prescription Drug Program

First Script, in conjunction with your employer, offers the finest in pharmacy benefit management programs designed specifically for workers’ compensation. Our nationwide pharmacy network and superior customer service make our pharmacy program more convenient than any other. Injured workers can fill their prescriptions at more than 67,000 retail pharmacy locations, which includes all major drug, mass retail and grocery store chains, plus 97% of local independent pharmacies—with no out-of-pocket expense.

Partial List of Participating First Script Pharmacies


Once your examiner determines you have a compensable claim, a First Script ID card will be mailed to you. Please note that First Script is valid only for medications prescribed to treat your work-related injury. If after using your First Script prescription card you switch to a different pharmacy for your workers’ compensation prescriptions, please call First Script Customer Service at 1.866.445.7344 with your new pharmacy name and phone number.
In accordance with Section 2e of Title 85 of the Oklahoma Statutes, an employee suffering from a work-related accident or illness may supplement his or her Workers’ Compensation Temporary Total Disability (TTD) with the use of any available sick or annual leave to the extent that he or she receives the equivalent of full wages during the absence from work.

The first three calendar days of absence will **NOT** be compensated by Workers’ Compensation, regardless of the leave election for that period of time. When leave is used to supplement Workers’ Compensation leave without pay, a separate warrant is prepared for that time and issued on a supplemental payroll.

**Leave Option Election**

For the First Three calendar days of absence, I elect to use:

- Annual Leave □
- Comp Time □
- Sick Leave □
- Leave Without Pay □
- Shared Leave □

For the remainder of my absence, I elect to use:

- **Only Leave Without Pay.** This will not supplement my TTD payments. □
- A combination of paid leave as indicated below. This will enable me to supplement my TTD payments. I have numbered my election(s) below in the order I wish to use them.
  - Annual leave until exhausted: __________
  - Regular comp time until exhausted: __________
  - Sick leave until exhausted: __________
  - Comp holiday until exhausted: __________
  - Shared leave, if eligible: __________

**Note:** Any Person receiving temporary disability benefits from any employer or the employer’s insurance carrier, must promptly report in writing to the employer or insurance carrier, any change in a material fact, or the amount of income he or she is receiving, or any change in the employment status, occurring during the period of receipt of such benefits.

I have read and understand this form and I hereby elect the above options for leave adjustments(s) to be made during my absence. I understand that this election may be changed by submitting a new Leave Option Election – Work-related Accident/Illness form. This leave option election is effective with the pay period in which it is received.

______________________________________________________________   ______________________
Signature of Employee                                                                                                   Date
Application for Purchase of Delinquent Service

This form is to be completed only by the Retirement Coordinator of a participating employer of OPERS. Use this form to certify employment during which an employee did not participate in OPERS, but may have been eligible to do so. If you need additional space, use a separate form.

**PART 1 – MEMBER INFORMATION**

Name (First, Middle, Last) ____________________________ Social Security number ____________________________

Agency name ____________________________ Agency number ____________________________

This form will be incomplete if employment status is not indicated. Check one: ☐ permanent ☐ temporary ☐ seasonal

**PART 2 – DELINQUENT SERVICE INFORMATION**

Provide the member’s gross salary and number of hours worked for each period of delinquent service.

<table>
<thead>
<tr>
<th>Pay period End date</th>
<th>Gross salary</th>
<th>Number of hours worked</th>
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**PART 3 – RETIREMENT COORDINATOR CERTIFICATION**

“Any person who shall knowingly make any false statement, or who shall falsify or permit to be falsified any record necessary for carrying out the intent of this act for the purpose of committing fraud, shall be guilty of a misdemeanor, and upon conviction shall be punished by a fine not exceeding Five Hundred Dollars ($500.00) or by imprisonment for not exceeding one (1) year.” 74 O.S. §924

I certify that the above employee information is correct according to the records of this participating employer.

Retirement Coordinator’s signature ____________________________ Date ____________________________

Oklahoma Public Employees Retirement System
P.O. Box 53007 | Oklahoma City, Oklahoma 73152-3007
Tel 405-858-6737 | Toll-free 1-800-733-9008 | www.opers.ok.gov

Rev. 8/2011
Tell us about the Employee

1. Check the category which best describes the employee’s regular type of job or work: (Optional)
   - ☐ Office, Professional, business, or management staff
   - ☐ Sales
   - ☐ Production assembly, product manufacture
   - ☐ Repair, Installation or service of machine, equipment
   - ☐ Construction
   - ☐ Healthcare
   - ☐ Delivery or driving
   - ☐ Food Service
   - ☐ Cleaning, Maintenance of building, grounds
   - ☐ Material handling (e.g. stocking, loading, unloading, moving etc)
   - ☐ Farming

2. Employee’s race or ethnic background: (Optional-Check one or more)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Hispanic or Latino
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Not Available

3. Employee’s age:________ OR date of birth: ________________
   - MM-DD-YYYY

4. Employee’s date hired: _____________________
   - MM-DD-YYYY

5. Employee’s sex: ☐ Male ☐ Female

6. Time employee began work: _________________ ☐ am ☐ pm

7. Time of Event: _______________ ☐ am ☐ pm OR ☐ Check if time cannot be determined

8. What was the employee doing just before the incident occurred? Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials”, “spraying chlorine from hand sprayer”, “daily computer key-entry".
9. **What happened?** Tell us how the injury or illness occurred. Example: When ladder slipped on the wet floor, worker fell 20 feet”, “Worker was sprayed with chlorine when gasket broke during replacement”, “Worker developed soreness in wrist over time”.

10. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than “hurt”. “pain”. Or “sore.” (These are symptoms, not injuries.) Examples: “strained back’. Chemical burn, hand”, “carpal tunnel syndrome.”

11. **What object or substance directly harmed the employee?** Example: “concrete floor”, “chlorine”, “radical arm saw.” If this question does not apply to the incident, leave it blank.

12. **Was the employee treated in an emergency room?** ☐ Yes ☐ No

13. **Was employee hospitalized overnight as an in-patient?** ☐ Yes ☐ No

14. **If the employee died, record date of death:** ________________

    MM-DD-YYYY