



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Employee's Report of Job-Related Accidental Injury or Illness

Workers' Compensation claim number: _____

Part I: Employee identifying information

Last name		First		Middle initial
Street address	City	State	Zip	
Social Security number	Home phone	Date of birth	Sex M/F	
Location of employment		Work phone		
Classification/job title		Monthly wage		
Hours of employment: _____ to _____		Regular days off		
Date of hire	Immediate supervisor			

Part II: Employee's report/notice of accident/injury

1. Date of injury/illness	2. Time	3. Location of injury/accident
---------------------------	---------	--------------------------------

4. Describe how the job-related accident, illness, or condition occurred, including the job being performed at the time:

Describe, in detail, the events which resulted in or caused the injury, illness, or condition, including the object and/or substance which injured you. If vehicular accident, also attach the police collision report and Department of Central Services Risk Management Division Form 001, Standard Liability Incident, and Form 002, Scope of Employment Report.

5. List the specific body part(s) injured as a result of the accident, illness, or condition:

6. Do you have a physical/mental limitation(s) as a result of this illness, accident, or condition which effects and/or restricts your continued job performance, or prevents you from returning to your position/duty assignment? (Describe):

Note: You will be required to submit a medical statement from the attending physician(s) relating to your illness, accident, and/or injury, describing the injury and the physical/mental limitation(s) you suffer as a result of the illness, accident, or injury.

7. Have you ever filed a claim(s) for Workers' Compensation? Yes No
If yes, when and where was the claim filed? _____ State: _____
8. Did the employee give notice of the job-related injury, illness, or condition either orally or in writing, within 60 days of the date of the accident or illness? Yes No
If yes, when and to whom? _____
9. Were other employees/persons injured? Yes No
10. If you were scratched, cut, and/or bitten, was the skin broken? Yes No
11. If you lost time from work due to the injury/illness, please give the last date worked:
Date: _____ Time: _____
If returned to work: Date: _____ Time: _____
12. If injury was client/pupil related, name and/or case number of the client/pupil:

13. Were you intoxicated, under the influence of medication(s)/drugs when the injury occurred? Yes No
14. Were you wearing any type of safety equipment when injured? Yes No
If yes, describe: _____
15. Did you require medical treatment for the injury, illness, accident, and/or condition?
Yes No (If yes, provide name and address of facility where treatment was performed, hospital, doctor(s), and first aid):

16. List any witnesses to the accident/illness or condition and their positions with OKDHS, if applicable.

Name	Position	Work phone

Upon filing this form, permission is given to the OKDHS Risk and Safety Management Unit and Compsource Oklahoma, or their designees, to examine all records related to this form, any matter contained in this form, and any matter relating to this form.

NOTE: Any person receiving temporary disability benefits from any employer or the employer's insurance carrier, shall 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 his or her employment status, occurring during the period of receipt of such benefits.

I hereby declare under the penalty of perjury/fraud that I have examined this form, and all statements contained herein, and to the best of my knowledge and belief, are true, correct, and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Signature of employee

Date

Routing instructions

Original to local OKDHS administrator and copies to the: local personnel officer, local safety officer, and Risk and Safety Management Unit.

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

MEDICAL AUTHORIZATION FORM AND RELEASE OF INFORMATION

Dear Claimant:

For expeditious processing of your Worker's Compensation Claim, please sign this medical authorization form below, and give your current mailing address. Compsource Oklahoma can take **NO ACTION** on your claim until they have received medical documentation from your doctor(s). Medical information **CANNOT BE RELEASED** without a signed medical authorization form. Your help and cooperation in this matter is greatly appreciated.

Date: _____

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to disclose, whenever requested to do so by **THE OKLAHOMA DEPARTMENT OF HUMAN SERVICES RISK AND SAFETY MANAGEMENT PROGRAM AND COMPSOURCE OKLAHOMA**, any and all information you may have concerning:

Name		Social Security number	
Street address	City	State	Zip

With respect to any illness, accident, or injury, medical history, consultation, prescriptions, or treatment, including by not limited to X-ray plates, and copies of all hospital or medical records. I further authorize the aforesaid agencies, to examine and/or obtain copies of all records relating to my injury, accident, or illness, any other matter relevant to the processing of my claim, or payment of disability benefits or my eligibility to receive such, or any matter contained in my claim, and or any matter relating to my claim. A photostatic copy of this medical authorization form shall be considered effective and valid as the original.

NOTE: By State Law, you must be advised, that: the information authorized for release may include information that could be considered information about communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signed: _____