Identify the site at which the accidental exposure/incident occurred and then follow the remainder of the instructions for that site.

**Site 1**

**LOCATION:**
ANY WSU OR DMC BUILDING

1) Report to UHC 4K Occupational Health
2) Inform Occupational Health that you are a WSU employee & were injured on job

**PLEASE INFORM OCCUPATIONAL HEALTH:**
to invoice WSU Office of Risk Management (ORM) 5700 Cass Ave., Suite 4622, Detroit, MI 48202

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**Site 2**

**LOCATION:**
HOSPITAL

1) Report to that Hospital’s Employee Health during business hours or ER after business hours
2) Inform Employee Health that you are a WSU employee & were injured on job

**PLEASE INFORM HOSPITAL EMPLOYEE HEALTH OR ER:**
to invoice WSU Office of Risk Management (ORM) 5700 Cass Ave., Suite 4622, Detroit, MI 48202

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**Site 3**

**LOCATION:**
DEARBORN SURGICAL CENTER

1) Report to OHMC Employee Health (basement MOB) for blood draw
2) Resident to provide incident report (from OakNet/Depts/Employee Health) with patient’s info to OHMC Employee Health to follow up

**PLEASE INFORM OHMC EMPLOYEE HEALTH:**
to invoice WSU Office of Risk Management (ORM) 5700 Cass Ave., Suite 4622, Detroit, MI 48202
REPORT OF INJURY FORM:
1. Download “Report of Injury” form from www.risk.wayne.edu or see last page
2. Have Program Director sign “Report of Injury” form as “supervisor”
3. Return completed form to GME office within 24 hours of injury
4. GME will submit completed “Report of Injury” form to ORM
5. Delay in submitting form may generate delinquent payment

REPORT TO OCCUPATIONAL HEALTH (UHC 4K):
the next business day for medical assessment & current work status
(Inform Occupational Health you are a WSU employee)

IF YOU MEET THE FOLLOWING CRITERIA:
- If employee received lab work:
  - Take results to UHC 4K for results review & a report generated so ORM is aware of employee medical issue
- If employee received treatment along with lab work:
  - Take results to UHC 4K and a medical report should be generated to ORM for review
- If medical report indicates need for 3-6 month treatment:
  - Employee should report to UHC 4K for follow up
- If medical report indicates no further treatment is necessary:
  - Employee does not need to follow up at UHC 4K

REPORT TO OCCUPATIONAL HEALTH (UHC 4K):
the next business day for medical assessment & current work status
(Inform Occupational Health you are a WSU employee)

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5. Delay in submitting form may generate delinquent payment
Report of Injury

Type or Print Neatly.

Name (Last, First, Middle) __________________________ Social Security No. __________________________

Address (Street, City, State, Zip) __________________________ Telephone No. __________________________

Date of Injury: __________________________ Time of Injury: A.M. __________________________ P.M. __________________________

Location (Building, Address or Area) __________________________

Accident Reported to: __________________________ Name __________________________ Title __________________________

Witnesses: __________________________

1. Full Name __________________________ Address (Street, City, State, Zip) __________________________ Telephone No. __________________________

2. __________________________

Treating Physician: __________________________ Full Name __________________________ Address __________________________

Hospital (if hospitalized): __________________________ Full Name __________________________ Address __________________________

Description of alleged injury: Complete information requested for each category. Be specific. Describe the injury or illness (i.e., amputation, burn, cut, fracture, sprain, etc.).

Part of body directly affected by the injury or illness (i.e., head, arm, leg, circulatory system, etc.).

Describe the events that caused the injury (i.e., fall, operating machinery, exposure to chemicals, etc.).

Name the object or substance which directly injured the person (i.e., knife, acid, floor, etc.).

Employees MUST complete the following information:

<table>
<thead>
<tr>
<th>Birthdate (mm/dd/yy)</th>
<th>If under 18, working permit date (mm/dd/yy)</th>
<th>Sex: Female Male</th>
<th>No. of Dependents (under age 16): If married, spouse is supported at least 50% by injured (specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Filing Single</td>
<td>Married, Filing Jointly</td>
<td>Single, Head of Household Married, Filing Separately</td>
<td>If married, spouse is supported at least 50% by injured.</td>
</tr>
</tbody>
</table>

Other family members supported at least 50% by injured (specify):

Lost Day(s)

Due to Injury: Yes No

Date of Last Day Worked: __________________________ Date returned to work/ estimated length of disability: __________________________

If approved for Workers’ Compensation, I would like my benefits supplemented 20%, utilizing any available Illness or Vacation time that I have. Yes No

Classification __________________________

Department __________________________

Date of Hire __________________________

<table>
<thead>
<tr>
<th>Supervisor’s Name</th>
<th>Hours Worked per week: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campus Address</td>
<td>Telephone No. __________________________</td>
</tr>
</tbody>
</table>

Second Employer (if applicable): __________________________

Address (Street, City, State, Zip) __________________________

Employee’s Signature/Date: __________________________

Supervisor’s Signature/Date: __________________________