OJI 1

Rev. 4-2003

AUBURN UNIVERSITY
REPORT OF WORK RELATED INJURY
Fax to Crawford & Co. (334) 279-7722

1.EMPLOYER'S NAME AND MAILING ADDRESS	LOCATION, IF DIFFERENT FROM MAILING ADDRESS
Auburn University **Department of Risk Management & Safety** **11C Ingram Hall** **Auburn University, Alabama 36849-5104** TELEPHONE NUMBER (334) 844-4533 Fax: 334-844-4942	Division: AU ( ) AUMC ( ) AAESC ( ) ACESC ( ) (No. & Street, City, County, State, ZIP)

2.EMPLOYEE'S NAME (Last) (First) (Middle)	3.SEX MALE ( ) FEMALE ( )	4.AGE	5.SOCIAL SECURITY NO.

6.EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)	7.MARITAL STATUS: SINGLE ( ) MARRIED ( ) DIVORCED ( ) SEPARATED ( ) WIDOWED ( )

8.HOME TELEPHONE	9.REGULAR OCCUPATION AND TITLE	10.WORKING IN WHAT DEPARTMENT WHEN HURT (Name and Dept. #)

11.PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)	12.ON EMPLOYER'S PREMISES? YES ( ) NO ( )

13.Date of Occurrence	14.TIME OF DAY a.m. ( ) p.m.( )	15.If applicable, Date Disability Began	16.Date Employer Notified

17.DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
(E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)

18.WHAT THING DIRECTLY PRODUCED THIS INJURY OR ILLNESS?
Name the object struck against or struck by vapor, poison, chemical or radiation; if strain or hernia, the thing being lifted, pulled, pushed, etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)

19.HOW DID THE ACCIDENT OR EXPOSURE OCCUR? Attach additional sheet if necessary.
(Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.)

(Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.) Could accident have been prevented? If so, how?

20.NAME AND ADDRESS OF TREATING PRACTITIONER	NAME AND ADDRESS OF HOSPITAL HOSPITALIZED ( ) OUT-PATIENT ( ) EMERGENCY TREATMENT ( )

21.Has Injured Returned to Work? Yes ( ) No ( )	22.If so, Date	23.At What Wage?	24.At What Occupation?

25.Length of Time Employed at AU? Years_____ Months_____	26.LENGTH OF TIME IN PRESENT JOB? Years_____ Months_____	27.Number of lost days

28.Pay Rate $	29. Pay Schedule is ( ) Biweekly ( ) Monthly	Employment Status ( ) FT ( ) PT ( ) Temp	30.DID EMPLOYEE RECEIVE FULL PAY FOR DAY OF INJURY? YES ( ) NO ( )

31.ARE YOU COVERED BY HEALTH INSURANCE? YES ( ) NO ( ) Your insurance, Spouse's, or Parent's If yes, Name and Policy #	32.INSURANCE CONTRACT #	33.INSURANCE GROUP #

34.Date of This Report	35.Employee's Signature	36.Supervisor's Signature & Department/Phone No.	37.Supervisor's Official Position or Title

All injured employees at the Auburn University Main Campus are required to seek medical attention from Auburn Univ. Medical Clinic first. Medical emergencies should be directed to the closest emergency room. Treatment for after-hour injuries, or injuries that occur away from the main campus should be obtained from a Blue Cross/Blue Shield provider if the injured employee is insured with Blue Cross/Blue Shield. Follow-up treatment after the initial visit must be <u>pre-approved</u> by the OJI administrator (1-800-844-2524.)