Identify the site at which the accidental exposure/incident occur

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

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

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/Em ployee Health) with patient's info to OHMC Employee Health to follow up



HEALTH

to invoice WSU Office of Risk Management (ORM) 5700 Cass Ave., Suite 4622, Detroit, MI 48202



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REPORT OF INJURY FORM:

 Download "Report of Injury" form from <u>www.risk.wayne.edu</u> or see last page 1

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- Have Program
 Director sign "Report of Injury" form as "supervisor"
- Return completed form to GME office within 24 hours of injury
- GME will submit completed "Report of Injury" form to ORM
- 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):

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REPORT OF INJURY FORM:

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 of Injury" form as
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- Return completed form to GME office within 24 hours of injury
- 4. GME will submit completed "Report of Injury" form to ORM
- Delay in submitting form may generate delinquent payment

Type or Print Neatly.

Type of Film	Neatly.					
Name (Last, First, M	liddle)				Social Security No.	
Address (Street, City	y, State, Zip)				Telephone No.	
Date of Injury:		Time of Injury:		A.M. P.M.		
Location (Building, A	Address or Area)					
Accident Reported to:				Title		
Witnesses: 1.	Full Name	Ill Name Address (Street, City, State, Zip) Telephone No.				
2.						
Treating Physician:	Full Name			Address		
Hospital (if hospitali:	zed): Full Name			Address		
Description o Describe the injury of	f alleged injury or illness (i.e., amputa	r: Complete informati tion, burn, cut, fracture, sprai	on requested n, etc.).	d for each categor	y. Be specific.	
Part of body directly	affected by the injury	or illness (i.e., head, arm, leg	g, circulatory syst	em, etc):		
Describe the events	that caused the injury	/ (i.e., fall, operating machine	ry, exposure to c	hemicals, etc.):		
Name the object or	substance which direc	ctly injured the person (i.e., kr	nife, acid, floor, e	tc):		
Employees I	MUST comple	ete the following in	nformation	1:		
Birthdate (mm		f under 18, working permit date (mm/dd/y	y)	Sex: Female Male	No. of Dependents (under age 16):	
Tax Filing	Single		Married, Fili	ng Jointly	If married, spouse is supported	
Status:	Single, Head of	ingle, Head of Household Married, Filing Separately at least 50% by injured.				
Other family me	mbers supported	at least 50% by injured	(specify):			
Lost Day(s) Due to Injury:						
If approved for Vacation time		pensation, I would like Yes No	e my benefit	s supplemented 2	0%, utilizing any available Illness or	
Classification	ı	Depa	ırtment		Date of Hire	
Supervisor's Na	me				Hours Worked per week:	
Campus Addres	s				Telephone No.	
Second Employe	er (if applicable):	Name				
Address (Street,	City, State, Zip)					
Employee's Sigr	nature/Date:					
Supervisor's Sig	nature/Date:					