

Broadspire Workers' Compensation Reporting Form

To report the injury the Department Supervisor must be prepared to answer the questions listed below
Before contacting Broadspire at 800-753-6737

Once form is completed you may fax to 800-245-9927 or Email to nol@choosebroadspire.com

Is this an Emergency Claim: Yes No Reported by: _____ Title: _____

Business Phone: (____) _____ Fax: (____) _____ E-mail: _____

Date of Accident (mm/dd/yy): _____ Time of Accident (hh:mm am/pm): _____

A. Employer Information

Parent Company Name: Oklahoma State University Department: _____

Address: 106 Whitehurst City: Stillwater State: OK Zip: 74078 County: Payne

Business Phone (405) 744-5449 Fax: (405) 744-8345 E-mail: _____

Location Code: (Division/Dept) _____ (example: AA C1015) Nature of Business: University

Class Code: (Office/Clerical: OFC or Other: OTH) _____

B. Insured Contact Information

Are You the Contact Person: Yes No

If No, Enter Contact Name: _____ Title: _____

Contact Phone (____) _____ E-mail: _____

C. Loss Location Information

Did Accident Occur on the Insured Premises: Yes No

If No, Enter Physical Address: _____ City: _____ State: _____ Zip: _____ County: _____

D. Employee Information

CWID: _____ Employee Name: _____ Birthday: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home Phone: (____) _____ Business Phone: (____) _____ Sex: Female Male

Number of Dependents: _____ Marital Status: _____

Regular Occupation: _____ Regular Department: _____ Class Code: _____

Date of Hire: _____ Hire County: _____ Hire State: _____

Employment Status: Full Time Part Time Pay Type: Monthly Bi-Weekly

Gross Wages (hourly/monthly): _____ Hours per Day: _____ Days per Week: _____ Hours per Week: _____

Supervisor Name: _____ Business Phone: (____) _____

E. Loss Information

Employee Start Time: _____ Date Employer Notified: _____ Questionable Case: Yes No

Description of Accident: _____

Removed by Ambulance: Yes No Unknown

Any Stitches/Surgery Required: Yes No Unknown

Was a Fatality Involved: Yes No (If Yes) Provide Date: _____

Describe Injury or Illness: _____

Body Part Injured (Indicate Right or Left): _____

Work Process Injured was doing: _____

Describe Preventable Measures: _____

Direct Cause: Auto Accident Faulty Machinery Someone's Negligence

If other, Describe Cause: _____

Describe Preventable Measures: _____

Safeguards or Safety Equipment Provided: Yes No Unknown

Safeguards or Safety Equipment Utilized: Yes No Unknown

Employee on Restricted Duty: Yes No Unknown

Full Pay for Day of Injury: Yes No Unknown

Any Lost Time: Yes No Undetermined

Last Day Worked: _____ Start Date of Disability: _____ Date Returned to Work: _____

Salary Continued During Disability: Yes No Unknown

F. Medical Information

Initial Treatment (Select Only One): No Medical Treatment Minor by Employer Minor Hosp/Clinic
 Emergency Care Hospitalized 24 hrs Future Medical/Lost Time Unknown

Physician Information

Hospital Information

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: __ Zip: _____

City: _____ State: __ Zip: _____

Business Phone: (____) _____

Business Phone: (____) _____

G. Witness Information

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State: __ Zip: _____

City: _____ State: __ Zip: _____

Phone: (____) _____

Phone: (____) _____

If you have any questions, please contact: 800-890-8975, ext 221 or 405-942-9986 Fax

Lisa Colbert
Broadspire Services, Inc.
1300 S Meridian, Suite 323
Oklahoma City, OK 73108-1751

Broadspire will give you a Claim Number: Please note below

Claim Number: _____