Oklahoma Department of Labor

Leslie Osborn

COMMISSIONER OF LABOR

_____ FATALITY REPORT

_____ MULTIPLE HOSPITALIZATION REPORT*

(Check ONE of the above)

MUST BE FILED WITHIN 48 HOURS OF THE INCIDENT

AGENCY NAME _____ TOWN/CITY _____ COUNTY _____ STATE _____ SCHOOL _____
(Check ONE)

FACILITY ID NO: _____

DIVISION _____ TELEPHONE & EXTENSION _____

ADDRESS _____
(Street or P O Box) (Town/City) (Zip)

PRINTED NAME, TITLE, TELEPHONE NUMBER, PHONE EXTENSION, EMAIL OF PERSON PREPARING THIS REPORT: **SIGNATURE**

***** EMPLOYEE INFORMATION *****

LAST NAME _____ FIRST _____ MIDDLE _____

COMPLETE HOME ADDRESS _____
(Street or P O Box) (Town/City) (Zip)

JOB DESCRIPTION/DUTIES _____

LENGTH OF EMPLOYMENT YEAR _____ MONTH _____ DAY _____

DATE OF BIRTH YEAR _____ MONTH _____ DAY _____

DATE OF INCIDENT YEAR _____ MONTH _____ DAY _____ TIME (24-hour format) _____

DATE OF DEATH YEAR _____ MONTH _____ DAY _____

INCIDENT DESCRIPTION/CAUSING AGENT (*Check one or more in each column*)

	ACCIDENT TYPE		**INJURY AGENT**
_____	Fall	_____	Machine
_____	Struck by	_____	Tool
_____	Struck against	_____	Vehicle
_____	Caught in, under, between	_____	Electrical apparatus
_____	Contact with electrical current	_____	Gas/fumes/emissions
_____	Contact with radiation, acid/caustics, toxic agent inhalation / absorption	_____	Chemical(s)
_____	Ingestion/injection of agent/chemical(s)	_____	Working surface
_____	Vehicle accident	_____	Earth, rock, stone, brick
_____	Public transportation accident	_____	Confined space, entrapment
_____	Contact with temperature extremes	_____	Collapsing trench, structure
_____	Exposure to COVID-19	_____	Policy/procedure/system failure
_____	Other (Describe) _____	_____	Complication/symptoms from COVID-19
		_____	Other (Describe) _____

LOCATION OF INCIDENT _____
(Street or Physical Address) (Town/City) (County) (Zip)

INCIDENT INVESTIGATED BY _____ TELEPHONE & EXTENSION _____

ADDRESS OF INVESTIGATOR _____
(Street or P O Box) (Town/City) (Zip)

REPORT FILED AT _____ COPY OF REPORT ATTACHED? _____ YES _____ NO

NOTE* *A multiple-hospitalization incident must involve at least **FIVE** (5) or more employees who are **HOSPITALIZED**. Use a separate form for **EACH** hospitalized employee.* *(REV. 20230330)*