

Oklahoma Department of Labor



Once completed, please email this form
to peosh@labor.ok.gov

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 _____
FACILITY ID NO: _____ (Check ONE)
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)

<u>ACCIDENT TYPE</u>	<u>INJURY AGENT</u>
_____ Fall	_____ Machine
_____ Struck Against	_____ Tool
_____ Struck by	_____ 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)
_____ / injection / ingestion	_____ Working surface
_____ Vehicle accident	_____ Earth, rock, stone, brick
_____ Public transportation accident	_____ Confined space, entrapment
_____ Contact with temperature extremes	_____ Collapsing trench, structure
_____ Other (Describe) _____	_____ Policy/procedure/system failure
	_____ 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. 07/2021)