WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	EMPLOYEE ID
ADDRESS (INCL ZIP)	**DATE OF HIRE**	**MARITAL STATUS**
		SINGLE ☐ MARRIED ☐
PHONE / **OTHER**	**SEX** M ☐ F ☐	**Internal Use Only:**
SCHOOL/DEPARTMENT	**LAST FOUR OF SSN**	**Appt. Office**
OCCUPATION/TITLE		**Appt. Date** / **Time**

DATE OF ACCIDENT / LOCATION OF ACCIDENT	START TIME OF SHIFT / TIME OF ACCIDENT	IMMEDIATE SUPERVISOR / WITNESS TO ACCIDENT

Tell us how the injury or illness occurred and what the employee was doing before the incident. (Give details). *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under the drive shaft." *Worker was cleaning blades on slicer and cut left ring finger"*

NATURE OF INJURY			PART OF BODY INJURED		
___ Abrasion	___ Cut	___ Scratch	___ Abdomen	___ Face	___ Leg (R / L)
___ Amputation	___ Dislocation	___ Shock	___ Ankle (R / L)	___ Finger	___ Mouth
___ Asphyxiation	___ Fracture	___ Sprain	___ Back	___ Foot (R / L)	___ Nose
___ Bite	___ Laceration	___ Splinter	___ Chest	___ Forearm (R / L)	___ Shoulder (R / L)
___ Bruise	___ Poisoning	___ Strain	___ Ear (R / L)	___ Hand (R / L)	___ Teeth
___ Burn	___ Puncture		___ Elbow (R / L)	___ Head	___ Wrist (R / L)
___ Concussion	___ Repetitive Stress Injury		___ Eye (R / L)	___ Knee (R / L)	
Other specify)			Other specify)		

****If you require medical attention contact Risk Management, (803) 231-7401, to schedule an appointment with an approved physician. Submitting fraudulent information is against the law and could result in termination. ****

I have agreed to submit this First Report by electronic means. By signing this First Report electronically, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Signature of Employee _____ **Date** _____

TO BE COMPLETED BY PRINCIPAL OR DEPARTMENT HEAD (IF APPLICABLE):

DATE YOU LEARNED OF ACCIDENT?	DID YOU INVESTIGATE THE ACCIDENT YOURSELF?	WHO NOTIFIED YOU OF THE ACCIDENT?	PHONE
	☐Yes ☐No		

What steps have you taken to prevent accidents such as this in the future?

Signature of Principal/Department Head (IF APPLICABLE)	Date	Phone Number	Mail Code

Carrier – SCSBIT ~111 Research Dr. ~Columbia, SC 29203~ (803) 326-3679

Email completed forms to: stacy.cunningham@richlandone.org and beverley.leeper@richlandone.org

Employee Acknowledgement

I, _____Acknowledge that on _____/_____/_____

(Printed *name)* (Date *of accident/incident)*

I sustained a work-related, on the job injury. The facts I have presented on the First Report of Injury are true and accurate. I am seeking medical care as a result of that injury. I understand presenting a false or exaggerated statement/injury in order to obtain Worker's Compensation benefits, or trying to *unjustly* benefit from the worker's compensation system in any way is illegal as deemed by South Carolina Law (Attorney General's Office of Insurance Fraud Division, State Accident Fund, etc.) and can be punishable by law.

I understand such actions if verified, are also subject to review under the District's Employee Code of Excellence Policy and may be subjected to further action(s) to include, but not limited to, immediate termination. By signing this agreement I attest that my answers are correct and complete.

_____ _____

Signature Date

Email completed forms to: stacy.cunningham@richlandone.org and beverley.leeper@richlandone.org

MEDICAL INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

IN RE: Claimant's name (Print):

SSN:

Date of birth:

You are hereby authorized and directed to furnish to the South Carolina School Boards Insurance Trust, or to its representative, adjuster, attorney or other agent, any and all information in your possession, or under your control relating to my medical or dental care, including but not limited to the following:

(a) Hospital records, x-rays, x-ray readings and reports, laboratory records, pharmacy records, and reports, all tests of any type or character, and reports thereof, statement of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expenses;

(b) Medical, dental, psychological, psychiatric, pharmacy, or chiropractic records, including patient's record cards, nurses and doctor's daily notes, x-rays, x-ray readings and reports, laboratory records and reports thereof, statements of charges, and any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

You are further authorized and directed to furnish oral and written reports and information to the South Carolina School Boards Insurance Trust, its representative, adjuster, attorney or other agent, as requested by it on any of the foregoing matters, and to allow it to review any records relating to my workers' compensation claim or to confer with it concerning my workers' compensation claim.

Date:

Claimant Signature

NOTE: A photocopy of this authorization shall have the same effect as the original.

RICHLAND ONE

Risk Management: Phone (803) 231-7401 or email:
Stacy.Cunningham@richlandone.org cc Beverley.Leeper@richlandone.org

WITNESS STATEMENT- Please Print

A copy of this form must be completed by every witness to the incident.

Name of Injured Person	
Incident Location	

Date of Incident		**Time of Incident**	
Name of Witness			
Description Please add as much detail as you can about the incident, circumstances, any injuries suffered and actions taken			

Additional Comments:

Witness Phone Number		**Alternate Number**	
Address			

I have completed this statement of the accident/ incident I witnessed and agree that all details are correct.			
Signed		**Date**	
Print Name			

Exhibit

WAGE AND SICK LEAVE VERIFICATION FOR WORKERS' COMPENSATION

Code **EGAA-E** *Issued* **08/23/02**

EMPLOYEE'S NAME: _____ SSN: ____ - __ - ____

SCHOOL/DEPARTMENT: _____

ACCIDENT: __/__/__ DATE DISABILITY BEGAN __/__/__

NUMBER OF DAYS OF ACCRUED SICK LEAVE: ____
(Risk Management has access to this information)

Please have the employee to sign <u>one</u> of the following options. By signing this form, the employee does not give up any rights to his/her claim.

<u>OPTION ONE</u>

I, _____ *(print name)* choose to use my accrued sick leave in lieu of worker's compensation benefits for lost wages. **Sick leave will no longer be reimbursed.**

Once my sick leave has been depleted, I elect to convert over to worker's compensation benefits.

☐ YES ☐ NO ☐ N/A

Signature: _____ Date: __/__/__

<u>OPTION TWO</u>

I, _____ *(print name)* choose to claim worker's compensation benefits for lost wages in lieu of using my sick leave.

Signature: _____ Date: __/__/__

****

(The employee's supervisor must sign this form.)

Employee Supervisor's Signature: _____

Print Name: _____ Date: __/__/__

IF YOU ARE OUT OF WORK SEVEN (7) CALENDAR DAYS OR LESS, SOUTH CAROLINA LAW PROHIBITS PAYMENT OF LOST WAGES.

Richland County School District One

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