

WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION

NAME (LAST, FIRST, MIDDLE) <input style="width: 90%;" type="text"/>		DATE OF BIRTH <input style="width: 60%;" type="text"/>	EMPLOYEE ID <input style="width: 60%;" type="text"/>
ADDRESS (INCL ZIP) <input style="width: 90%;" type="text"/>		DATE OF HIRE <input style="width: 60%;" type="text"/>	MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/>
PHONE <input style="width: 60%;" type="text"/>	OTHER <input style="width: 60%;" type="text"/>	SEX M <input type="checkbox"/> F <input type="checkbox"/>	Internal Use Only: Appt. Office Appt. Date Time
SCHOOL/DEPARTMENT <input style="width: 90%;" type="text"/>		LAST FOUR OF SSN <input style="width: 60%;" type="text"/>	
OCCUPATION/TITLE <input style="width: 90%;" type="text"/>			
DATE OF ACCIDENT <input style="width: 60%;" type="text"/>	START TIME OF SHIFT <input style="width: 60%;" type="text"/>	IMMEDIATE SUPERVISOR <input style="width: 90%;" type="text"/>	
LOCATION OF ACCIDENT <input style="width: 60%;" type="text"/>	TIME OF ACCIDENT <input style="width: 60%;" type="text"/>	WITNESS TO ACCIDENT <input style="width: 90%;" type="text"/>	

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		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg (R / L)
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock	<input type="checkbox"/> Ankle (R / L)	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> Foot (R / L)	<input type="checkbox"/> Nose
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter	<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm (R / L)	<input type="checkbox"/> Shoulder (R / L)
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain	<input type="checkbox"/> Ear (R / L)	<input type="checkbox"/> Hand (R / L)	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture		<input type="checkbox"/> Elbow (R / L)	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist (R / L)
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress Injury		<input type="checkbox"/> Eye (R / L)	<input type="checkbox"/> Knee (R / L)	
<input type="checkbox"/> Other specify)			<input type="checkbox"/> 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? <input style="width: 90%;" type="text"/>	DID YOU INVESTIGATE THE ACCIDENT YOURSELF? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHO NOTIFIED YOU OF THE ACCIDENT? <input style="width: 90%;" type="text"/>	PHONE <input style="width: 90%;" type="text"/>
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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