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	START TIME OF SHIFT	IMMEDIATE SUPERVISOR
LOCATION OF ACCIDENT	TIME OF ACCIDENT	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