WCSD Workers' Compensation Locations

ALL work-related injuries should be reported to an administrator or supervisor immediately!

1. **McLeod Occupational Health, Sumter**

   540 Physicians Lane
   Sumter, SC 29150
   (843) 848-8121

2. **McLeod Occupational Health, Florence**

   101 William H. Johnson St, Suite 150
   Florence, SC 29506
   (843) 777-5146

3. **McLeod Occupational Health, I-95/Commerce Park**

   3257 General Williams West Drive
   Florence, SC 29506
   (843) 777-1290

4. **McLeod Loris/Seacoast Hospital**

   3655 Mitchel Street
   Loris SC 29569
   (843) 777-2955

Please Note:
If immediate action is needed, an injured worker can go to the nearest ER for treatment.
In the case of a head injury, injured workers can go to the ER first, in case a scan is needed.
If a coach is injured at an away game, they can go to the closest ER for initial treatment, the same is applicable for a teacher on a field trip.

If **non-emergency** medical treatment is needed, see the school nurse for treatment and referral as needed.

If **emergency** medical treatment is needed, go to the nearest emergency room and follow up with a visit to any of the following locations.

MUSC Health Black River Medical Center
3555 N. Williamsburg County Hwy
Cades, SC 29518
Telephone: 843-210-5000

Lowcountry Urgent Care-Lake City
808 US-52
Lake City, SC 29560
Telephone: (843) 625-6080
Mon-Fri: 8am -8pm

PLEASE NOTE THAT ADDITIONAL AUTHORIZATION IS NEEDED BEFORE SEEKING CARE

- SC School Boards Insurance Trust is the Worker's Compensation Carrier for the school district.
- District Contact: Samantha C. Lewis, 843-355-5571 ext. 6137 sclewis@wcsd.k12.sc.us

Revised 2/1/2024

MEDICAL INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

IN RE: Claimant's name _____
SS Number _____
Date of Birth _____

For the purposes of Workers' Compensation claim adjudication, 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.

The patient understands that the information disclosed pursuant to this authorization may be subject to re-disclosure for investigative purposes and/or medical referrals, opinions, and decision-making related to my care.

***The signed authorization shall not expire, and shall not be revoked so long as the claim for Workers' Compensation benefits is open and/or actively pursued, unless otherwise determined by lawful agreement.**

*Date:_____ _____
PATIENT/CLAIMANT SIGNATURE

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

INCIDENT REPORT

(Please Answer Every Question)

Your Name: _____
First Middle Last

Your Employer's Name: _____

Your School Location: _____

Your Address: _____
Street City State Zip

Telephone Number: _____(home) _____(cell)_____(work)

Social Security: _____ Age: _____ Date of Birth: _____

Job Title: _____ Length of Employment: _____

Email address: _____

Date of Injury: _____ Time of Injury: _____am _____pm

Location of Incident:_____

Describe how you were injured: _____

_____

_____

Describe the type of injury (ex. bruise, contusion, strain, sprain, etc.)_____

_____

Did your injury occur from one specific incident? _____ If yes, explain in detail. _____

_____

Did your injury develop gradually over a period of time? _____ If yes, indicate period of time:

From: _____ _____ To: _____ _____ Describe how injury developed. _____
Date Time Date Time

_____

_____

_____

Is there any way, other than described above, that you possibly could have injured yourself?
Yes ____ No ____ If so, please give details.

_____

_____

Explain what caused your injury: (Example: What caused you to fall). _____

_____

_____

If you were lifting or moving an object when you were injured, describe the object: _____

_____

Give the approximate weight of the object: _____

Incident Report

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Describe the position you were in when you were injured: (Example: Sitting, Standing, Squatting, Bending).

_____

_____

When did you first realize you were injured? _____ (Date) _____ (Time). **When did you first feel the pain?** _____ (Date) _____ (Time) **Who at work, did you first tell about your injury?** _____

_____ **When did you tell them?** _____ (Date) _____ (Time). **When did you first tell your immediate supervisor of your injury?** _____ (Date) _____ (Time). **Name of your supervisor you reported your injury to :** _____. **If injury was not reported to your supervisor on the date you were injured, state the reason it was not reported:** _____

_____

Name(s) of person(s) who witnessed your injury: _____

List parts of your body injured: _____

List type of injury (ex. bruise, contusion, strain, sprain)_____

Names & Addresses of Physician(s) who have treated you for this injury:

_____

_____

Name & Address of Hospital: _____

_____

Have you lost time from work due to this injury? ___ (Yes) ___ (No) **If so, indicate the first day you missed from work?** _____ **If so, indicate the date you returned to work after this injury?** _____

Additional Remarks: _____

_____

_____

* **I certify that the answers given to the questions on both pages (2) of this Incident Report are correct and accurate to the best of my ability and recollection.**

_____ _____

Employee Signature **Date**

REV 08/29/22

Injured Employee's Name:_____ **Date of Injury:** _____

Witness Statement

Your Name: _____ Age: _____

Your Address: _____

Phone Number: _____ Job Title: _____

How long have you worked for the district? _____

How long have you known the injured employee? _____

Did you see the injury occur? _____

How did the injury occur? (In your own words) _____

When were you first aware of the injury? Date:_____ Time:_____

Did the injured employee state when the injury occurred or did you learn of this injury by someone other than the injured employee? _____

When did the injured employee first say he/she felt pain? Date/Time: _____

In your opinion, could the injury have occurred other than as stated by the injured employee? Please explain: _____

To your knowledge, did the injured employee report the injury to his/her supervisor at the time of the injury? Please explain how you were aware of this: _____

If so, when? Date: _____ Time: _____

Supervisor's name to who injury was reported: _____

Do you know of any other witnesses to this injury? _____

If yes, please list their names: _____

What part(s) of the body did the injured employee state was injured? _____

Please provide any information you feel should be considered in evaluating this claim:

- By signing this witness statement, I find the information I have provided is true and accurate to the best of my knowledge.

Witness's Signature: _____ Date: _____