WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

SIC CODE | EMPLOYER FEIN | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #: | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)
SC SCHOOL BOARDS INSURANCE TRUST
111 Research Drive
Columbia, SC 29203
ATTN: DANNY DEAL

POLICY PERIOD
TO

CHECK IF APPROPRIATE
X SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
SAME

CARRIER FEIN | POLICY/SELF-INSURED NUMBER **SF 0926** | ADMINISTRATOR FEIN **SAME**

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX: MALE / FEMALE / UNKNOWN

MARITAL STATUS: UNMARRIED SINGLE/DIVORCED / MARRIED / SEPARATED / UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: DAY / WEEK / MONTH / OTHER: | # DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? YES / NO | DID SALARY CONTINUE? YES / NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM / PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE AM / PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES / NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES / NO | WERE THEY USED? YES / NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT
- MINOR: BY EMPLOYER
- MINOR CLINIC/HOSP
- EMERGENCY CARE
- HOSPITALIZED > 24 HRS
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

SEE BACK FOR IMPORTANT STATE INFORMATION

INCIDENT REPORT

(Please Answer Every Question)

Your Name: ____
First Middle Last

Your Employer's Name: ______________________________________

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

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

Page 2:

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. 09/05

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: ____________

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.

Notice to Provider

(To be presented to doctor, hospital, or clinic by injured party when reporting for treatment)

________________________________ has reported that he/she was injured in our
(employee name)

employ on ______________________.
(date of injury)

Please forward all reports and bills to

South Carolina School Boards Insurance Trust
Attn: Workers' Compensation
111 Research Drive • Columbia, SC 29203
1-800-326-3679

or

email to
Danny Deal
ddeal@scsba.org

________________________________ ______________
School Location / Employer Phone

________________________________ ______________
Employer Signature (authorizing treatment) Date

________________________________ ______________
Approved Physician for treatment Phone

NOTE: This is not an acceptance of liability.

Return to Work Notice
(To be completed by Doctor after examining employee)

Name of Doctor's Office/Clinic ________________________________

Location ________________________ Phone ______________

Diagnosis ________________________________

☐ Employee **IS** able to return to regular duties at this time.

☐ Employee **IS** able to return to light duties at this time, **list limitations:** ______________

____

☐ Employee **IS NOT** able to return to work at this time because: ______________

____

________________________________ ______________
Request Referral to: (if applicable) Follow-up appointment date

________________________________ ______________
Signature (Doctor) Date

Please return completed form to patient to be returned to School / District Office.

Original copy: District Office Pink Copy: Patient

WCSD Workers' Compensation Locations

1. McLeod Occupational Health, Sumter

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

2. McLeod Occupational Health, Florence

149 N. Ravenel Street
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.

Revised 9/10/2020