WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Marion County Schools
719 N. Main Street
Marion, SC 29571

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE: **00926**

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #:

PHONE #

SIC CODE

EMPLOYER FEIN: **45-5423078**

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)
SC SCHOOL BOARDS INSURANCE TRUST
1027 BARNWELL STREET
COLUMBIA, SC 29201
ATTN: DANNY DEAL

POLICY PERIOD

TO

CHECK IF APPROPRIATE
[X] SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER: **SF 0926**

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE: **SC**

ADDRESS (INCL ZIP)

SEX
[ ] MALE
[ ] FEMALE
[ ] UNKNOWN

MARITAL STATUS
[ ] UNMARRIED SINGLE/DIVORCED
[ ] MARRIED
[ ] SEPARATED
[ ] UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS: 0

NCCI CLASS CODE

RATE PER: [ ] DAY [ ] WEEK [ ] MONTH [ ] OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? [ ] yes [ ] NO

DID SALARY CONTINUE? [ ] YE [ ] 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: _____ **Social Security:** _____ **Age:** _____

Date of Birth: _____ **Job Title:** _____ **Length of Employ:** _____

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

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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. 09/05

Witness Statement

Claimant's Name : _____ **DOI:** _____

Your Name: _____ **Age:** _____

Your Address: _____

Phone Number: _____ **Job Title:** _____

How long have you worked here? _____

How long have you known the claimant? _____

Did you see the injury occur? _____

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

_____
_____
_____
_____

Did the injured employee state when the injury occurred or did you learn of this injury by someone other than the injured employee?
When were you first aware of the injury?

Date: _____ **Time:** _____

_____
_____
_____

When did the injured first say he/she felt pain?

Date: _____ **Time:** _____

In your opinion, could the injury possibly occurred other than as alleged By the injured employee? _____ **If yes, please state why:**

_____
_____

Did the employee report the injury to his/her supervisor at the time of Injury? (to your knowledge) _____

If so, when? Date: _____ **Time:** _____

Supervisor's name to whom injury was reported? _____

If you know that the injury was reported to a supervisor, please state how you know this:

_____
_____

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

If yes, please list their names:

_____

What part(s) of the body did the employee mention that they injured?

_____

If there was an object involved that you feel caused the injury, describe the object: _____ **Approx. lb. of object:** _____

Any other information you feel should be considered in evaluating this claim?

_____
_____
_____

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

Witnesses Signature: _____ **Date:** _____

MEDICAL INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

IN RE: Claimant's name _____
SS Number _____
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. The signed authorization shall not expire as so long as the claim for Workers' Compensation benefits is open and/or active.

SCSBIT
THE SOUTH CAROLINA
SCHOOL BOARDS INSURANCE TRUST

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 the following address:

South Carolina School Boards Insurance Trust
Attn: Workers' Compensation
1027 Barnwell Street
Columbia, SC 29201-3834

_____ _____
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

WAGE AND SICK LEAVE VERIFICATION FOR WORKERS' COMPENSATION

EMPLOYEE'S NAME: _____

SSN: _____

SCHOOL / DEPARTMENT: _____

DATE OF ACCIDENT: _____

DATE DISABILITY BEGAN: _____

NUMBER OF DAYS OF ACCRUED SICK LEAVE: _____

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

I, _____ CHOOSE TO USE MY ACCRUED SICK LEAVE IN LIEU OF WORKERS' COMPENSATION BENEFITS FOR LOST WAGES.

I, _____ CHOOSE TO CLAIM WORKERS' COMPENSATION BENEFITS FOR LOST WAGES IN LIEU OF USING MY SICK LEAVE.

Employee's Supervisor: _____ _____
Signature Printed Name

Payroll Department: _____ _____
Signature Printed Name

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

PROCEDURES FOR REPORTING WORK-RELATED INJURIES
(Workers' Compensation Claims)

1. The employee must report a work related injury to the personnel office or nurse at his or her school. The Incident Report (2 pages) must be completed even though you may not go to the doctor. This form is necessary for future reference. The injury must be reported **(within 24 hours)** no matter how minor it may seem. Medical attention may not be required at the time of the injury, but could be needed in the future.

2. A 12-A form must be completed in the district office by the person designated to handle the workers' compensation insurance. The information for this report is taken from the Incident Report, which is completed and signed by the injured person.

3. If medical assistance is needed at a later date, the employee should inform the designated person at the district office. The district office will contact the appropriate Adjuster at SC School Boards Insurance Trust to schedule an appointment with an authorized treating physician. If a specialist is needed, a referral will be made by the authorized treating physician.

I understand and agree to follow the above procedures.

_____ _____

Signature of Employee Date