

To Be Completed by Supervisor

Please type or print answers in ink only. Information must be complete, true and accurate. **A copy must be faxed to CompEndium Services, Inc. at 1. 877.710.2667 and emailed to the Central Benefits Office at workerscomp@mailbox.sc.edu.**

Name of Injured Employee: _____ USCID of Injured Employee: _____

Department of Injured Employee: _____ Job Title of Injured Employee: _____

Date of Employee's Injury: _____ Time of Injury: _____ Date You Learned of This Injury: _____

How did you learn of this injury?
 I witnessed the accident. The employee notified me. Another employee notified me. Other (please explain) _____

How did the injury occur?

Where did the injury occur?(be specific: location, campus, building):

Were safeguards or safety equipment provided? Yes No N/A
 If yes, describe the safeguard(s) provided (goggles, gloves, seatbelt etc.): _____
 If yes, was the employee using the safeguard(s) at the time the injury occurred? Yes No

What were the circumstances that led to this injury (to include unsafe acts, unsafe conditions, system deficiencies)?

What corrective action measures will be implemented to prevent similar incidents from re-occurring? _____

Who will be responsible for implementing these corrective measures? _____

Did you (or an HR Representative) and the injured employee call Compendium together to report the injury? Yes No

Has the employee completed the Employee Injury Report Form (81-B)? Yes No

If yes, do you agree with the employee's statements on the Employee Injury Report Form (81-B)? yes No
 If no, please explain: _____

Has the employee received or is scheduled to receive medical treatment? Yes No
 If yes, has the employee received work restrictions from the treating physician? Yes No
 If yes, is the department able to accommodate the work restrictions that have been given? Yes No

Has or will the employee miss time from work **beyond** the date of the injury? Yes No

***If yes, please ensure that the employee has selected a Workers' Compensation Benefits Election (Option 1, Option 2 or Option 3).**
 If yes, has or will the employee miss more than 3 consecutive days from work? Yes No
 If yes, the employee **must** submit a completed FMLA Employee Medical Certification Form.

Please Note: An injured employee must provide copies of all physician's notes (which should include work status, work restrictions, and date of following appointments) to their supervisor, the Department Human Resources Contact and to the Central Benefits Office.

Did the injury result in a fatality, inpatient hospitalization, amputation or loss of an eye? Yes No

If yes, please call Environmental Health and Safety (1.803.528.8191) immediately.

Supervisor's Name: _____ Supervisor's Job Title: _____

Supervisor's Phone: _____ Supervisor's Email: _____

Supervisor's Signature (Sign and Date in Blue Ink): _____ Date: _____

HR Representative's Signature (Sign and Date in Blue Ink): _____ Date: _____