

FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP):		INDUSTRY CODE:	EMPLOYER FEIN:
Clemson University 391 College Ave., Suite 202 Clemson, SC 29634		611310	57-6000254
CARRIER/CLAIMS ADMINISTRATOR			
State Accident Fund PO Box 102100 Columbia, SC 29221 1-800-521-6576		POLICY PERIOD: 7/1/2023 TO 6/30/2024	
		ADJUSTER'S NAME: Amy Burkhardt	
EMPLOYEE/WAGE			
NAME (Last, First, Middle):	DATE OF BIRTH (MM/DD/YYYY):	DATE HIRED (MM/DD/YYYY):	DAYS WORKED/WEEK:
ADDRESS (Include Zip Code):	GENDER:	MARITAL STATUS:	OCCUPATION/JOB TITLE:
	Male Female Unknown	Single/Divorced Married Separated Unknown	EMPLOYMENT STATUS:
PHONE:			
RATE PER: \$ _____ Hourly Salary		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 (MM/DD/YYYY):	LAST WORK DATE (MM/DD/YYYY):	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN:
	TIME OF OCCURRENCE: () Cannot Be Determined _____ AM _____ PM		
CONTACT NAME/PHONE NUMBER:	TYPE OF INJURY/ILLNESS:		PART OF BODY AFFECTED:
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO		DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILL- NESS EXPOSURE OCCURRED:	
ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:			
SPECIFIC ACTIVITY/WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN THE 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:			
DATE RETURN(ED) TO WORK (MM/DD/YYYY):	IF FATAL, GIVE DATE OF DEATH (MM/DD/YYYY):	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO	WERE THEY USED? YES NO
PHYSICIAN/HEALTH CARE PROVIDER (Name & Address):	HOSPITAL OR OFF SITE TREATMENT (Name & Address):		INITIAL TREATMENT: No Medical Treatment Emergency Care Hospitalized > 24 Hours
WITNESS (Name & Phone #):			
DATE AMINISTRATOR NOTIFIED:	DATE PREPARED:	PREPARER'S NAME & TITLE:	PHONE NUMBER:
*Please attach pictures of equipment used during injury & surrounding area.			