

**CLEMSON UNIVERSITY
WORKERS' COMPENSATION REPORT OF INJURY**

EMPLOYEE NAME: _____ DEPT NUMBER: _____

HOME ADDRESS: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ a.m. _____ p.m.

DATE SUPERVISOR NOTIFIED OF ACCIDENT: _____

WHAT WAS EMPLOYEE DOING WHEN THE ACCIDENT OCCURRED? _____

HOW DID THE ACCIDENT HAPPEN? (DESCRIBE IN DETAIL ALONG WITH BUILDING, ROOM NO.) _____

PLEASE PROVIDE PICTURES OF ACCIDENT SCENE & EQUIPMENT USED DURING ACCIDENT.

TYPE OF INJURY: _____

WHAT BODY PARTS WERE AFFECTED? _____

NAME OF DOCTOR WHO TREATED EMPLOYEE: _____

STATE LOSS OF TIME FROM WORK: _____

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? _____ YES _____ NO

WERE THEY USED? _____ YES _____ NO

NAME OF WITNESS: _____ TELEPHONE #: _____

DOES EMPLOYEE HAVE 2ND JOB? IF YES, NAME & PHONE # OF EMPLOYER: _____

CIRCUMSTANCES, WHICH LED TO ACCIDENT: _____

EXPLAIN HOW THIS ACCIDENT *WILL BE PREVENTED* IN THE FUTURE: _____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

Form to be completed by the injured employee and signed by the supervisor. Submit form to **Risk Services & Insurance**
Fax: 864.656.4558 Email: WCRiskManagement@Clemson.edu 391 College Ave, Suite 202, Clemson, SC 29634