WORKERS' COMPENSATION-FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP):	INDUSTRY CODE:	EMPLOYER FEIN:
Clemson University E-306 Martin Hall Clemson, SC 29634	611310	57-6000254

CARRIER/CLAIMS ADMINISTRATOR

State Accident Fund PO Box 102100 Columbia, SC 29221 1-800-521-6576	POLICY PERIOD: 7/1/2018 TO 6/30/2019 ADJUSTER'S NAME: Jessica Backman

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:	DATE OF INJURY/ILLNESS (MM/DD/YYYY):	LAST WORK DATE (MM/DD/YYYY):	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN:
_____ ☐ AM ☐ PM	TIME OF CCURRENCE: ( ) 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?	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
☐ YES ☐ NO	

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.

SUBMIT