Human Resources

Supervisor Report of Injury Form (81-C)

Reset Form

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-occuring?_____

_____

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 recieve 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 fom 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) immedatley.

Supervisor's Name:	Supervisor's Job Title:
Supervisor's Phone:	Supervisor's Email:
Supervsor's Signature (Sign and Date in Blue Ink):	Date:
HR Representative's Signature (Sign and Date in Blue Ink):	Date: