S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)
Riaan J Patel

DATE OF BIRTH
12/08/2021

SOCIAL SECURITY NUMBER
987-44-6123

DATE HIRED
01/01/2022

STATE OF HIRE
NE

ADDRESS (INCL ZIP)
test address

SEX
☑ Male
☐ Female
☐ Unknown

MARITAL STATUS
☐ Unmarried/Single/Divorced
☐ Married
☑ Separated
☐ Unknow

OCCUPATION/JOB TITLE
In school

EMPLOYMENT STATUS
FULL TIME

NCCI CLASS CODE

PHONE

OF DEPENDENTS

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

DAYS WORKED/WEEK
7

FULL PAY FOR DAY OF INJURY? ☐ YES ☑ NO

DID SALARY CONTINUE? ☑ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK
04:30 ☑ AM ☐ PM

DATE OF INJURY/ILLNESS
02/02/2022

TIME OF OCCURRENCE
05:30 ☐ AM ☑ PM

LAST WORK DATE
03/03/2022

DATE EMPLOYER NOTIFIED
04/04/2022

DATE DISABILITY BEGAN
05/05/2022

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS
Concussion

PART OF BODY AFFECTED
Teeth

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?
☐ YES ☑ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
Accident ....

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
QUIPMENT, MATERIALS, OR CHEMICALS EMPLOYE

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
ACTIVITY THE EMPLOYEE WAS ENGAGED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
ROCESS THE EMPLOYEE WA

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
LLNESS/ABNORMAL HEALTH CONDITI

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK
06/06/2022

IF FATAL, GIVE DATE OF DEATH
07/07/2022

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☑ YES ☐ NO

WERE THEY USED? ☐ YES ☑ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
SITE TREATMENT

INITIAL TREATMENT
☑ No Medical Treatment
☐ MINOR: BY EMPLOYER
☑ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☑ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)
wit 1 - 6544 , wit 2 - 45566 , wit 3 - 45455

DATE ADMINISTRATOR NOTIFIED
08/08/2022

DATE PREPARED
09/09/2022

PREPARER'S NAME & TITLE
Hetal Thummar

PHONE NUMBER
963-258-7415

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.