



To Be Completed by Employee's Supervisor

Please type or write answers in ink only. Missing or incomplete information may delay the processing of a claim. **A copy of this form must be emailed both to CompEndium at customerservice@compendiumusa.net and 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-occurring?

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:

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) immediately.

Has the employee received or is scheduled to receive 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

Please ensure that the employee completes the Workers' Compensation Benefits Election on Form 81-B regardless of if any time is missed should they need to be medically placed out of work at a later date due to the work-related injury. Failure to select an option timely may delay the payment of WC benefits.

Has or will the employee miss time from work beyond the date of the injury? Yes No

If yes, has or will the employee miss more than 3 consecutive days from work? Yes No

If yes, the employee must complete a [USC Family Medical Leave Act Packet](#).

Please Note: An injured employee must provide copies of all physician's notes, to include work status, work restrictions, or dates of upcoming appointments, to their supervisor and department HR contact.

Supervisor's Name:	Job Title:
Supervisor's Phone:	Email:
Supervisor's Signature:	Date:
HR Representative's Signature:	Date: