ACORD™ WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Horry County
PO Box 997
Conway, SC 29528

Department Administration

CARRIER CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

LOCATION CODE

SIC CODE

EMPLOYER FEIN

57-6000365

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

PHONE #

CARRIER/CLAIMS ADMINISTRATOR

S.C. Counties Workers' Compensation Trust
PO Box 8207
Columbia, SC 29202-8207

POLICY PERIOD

TO

CHECK IF APPLICABLE

☐ **SELF INSURANCE**

CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)

SC Counties Workers' Compensation Trust
claims@scac.sc
PO Box 8207
Columbia, SC 29202-8207
1-803-252-7255

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

VOLUNTEER
☐ YES ☐ NO

EMPLOYMENT STATUS
☐ F/T ☐ P/T

INMATE
☐ YES ☐ NO

PHONE #
(H) (W)

OF DEPENDENTS

NCCI CLASS CODE

EMPLOYEE EMAIL

RATE
PER

☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/SUPERVISOR/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

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

WILL EMPLOYER PROVIDE MODIFIED DUTY, IF NEEDED? ☐ YES ☐ NO

PART OF BODY AFFECTED

DEPARTMENT OR LOCATON WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

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

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

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OF SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

Panel Physician Utilized? ☐ YES ☐ NO ☐ N/A

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR:BY EMPLOYER
☐ MINOR CLINIC HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HRS
☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

ACORD 4 (7/97) **SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE**

S&E Report Employee Incident Report (Complete/email within 24 hours to rmclaims@horrycounty.org)

1. Immediately report incident or damage to your supervisor. Send completed report to Risk Management within 24 hours of incident.

A. TYPE OF INCIDENT - *CIRCLE ALL THAT APPLY*

☐ 1000 - Motor Vehicle Incident ☐ 1001 - County Vehicle Damages ☐ 1002 - Personal Injury/Illness ☐ 1003A - Non-County Property Damage ☐ 1003B - Non-County Employee Injury ☐ 1006 - Damage to other County Property

B. EMPLOYEE INFORMATION **Print Department Name:**

Last Name	First Name	MI	Age
ID. #	Position/Title	Supervisor's Name	

EMPLOYEE GENDER

☐ 1007 - Male ☐ 1009 - Full- Time
☐ 100 Female ☐ 1010 - Part- Time

EMPLOYEE STATUS

☐ 1011- Temporary (FT - PT) ☐ 1013- Non-County Employee
☐ 1012- Volunteer

Incident Date	Time of Incident ☐ AM or ☐ PM	Incident Location
Vehicle Year / Model or Other Property Description		Seat belts used ☐ YES ☐ NO
VIN or Serial #		Asset #
DescribeProperty Damages		Employee cited ☐ YES ☐ NO
Passengers Name and Address		
Personal Injury ☐ YES ☐ NO Describe:		

NUMBER OF HOURS INTO SHIFT

☐ 1024- 0-1 Hour ☐ 1025- 2-3 Hours ☐ 1026- 4-5 Hour ☐ 1027- 6-7 Hours ☐ 1028- 8-9 Hours ☐ 1029- 10 Hours or more

DESCRIPTION OF INCIDENT IN THE EMPLOYEE's WORDS (Print or Type and Attach Additional Statements)

C. Other Driver, Claimant, Other Party, or Other Owner Information: Attach Statements of Non-County Employees

Name, Address, and Telephone Number

Insurance Company / Policy #:

Personal Injury ☐ YES ☐ NO Describe:

Vehicle Year / Model or Other Property Description

VIN or Serial #

Describe Property Damages

Claimant statement attached ☐ YES ☐ NO

Employee Signature	Today's Date	Date Reported to Supervisor

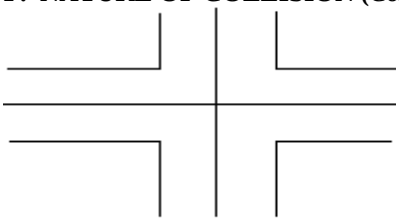
D. WITNESSES: List Names, Addresses, and Phone Numbers. Attach Witness Statements. Get them before they forget.

E. INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

☐ 1136 - First Aid Treatment ☐ 1138 - Medical Treatment Provided by: _____ ☐ 1139 - No Treatment Required

☐ 1137- Lost Workdays ☐ 1140 - Restriction of Work Activities ☐ Yes ☐ No

F. NATURE OF COLLISION (Complete/modify diagram/provide pictures)



Type	Road Surface	Weather Conditions
☐ 1141 - Single Vehicle	☐ 1147 - Wet	☐ 1152 - Clear
☐ 1142 - Multi-Vehicles	☐ 1148 - Dry	☐ 1153 - Cloudy
☐ 1143 - Parked Vehicle	☐ 1149 - Snow or Ice	☐ 1154 - Foggy
☐ 1144 - Heavy Equip.	☐ 1150 - Mud or Other	☐ 1155 - Raining
☐ 1145 - Backing	☐ 1151 - Unknown	☐ 1156 - Snowing
☐ 1146 - Other: _____		☐ 1157 - Other/Unknown

INVESTIGATION

Check All Boxes That Apply:	***DIRECT CAUSES***	**BASIC CAUSES**
UNSAFE ACTS OF INDIVIDUAL	***UNSAFE CONDITIONS OF WORK AREA OR EQUIP.***	**AREAS FOR DEPARTMENT/ SUPERVISOR/INDIVIDUAL IMPROVEMENTS because of**
☐ Failure to follow procedures	☐ Inadequate guards or protection	☐ Inadequate hiring/placement practices
☐ Failure to use safe practice or personal protective equipment	☐ Defective tools, equipment, machine or vehicle	☐ Procedures not enforced or inadequate training/procedures
☐ Physical or mental limitations	☐ Congested work area/roadways	☐ Improper layout or design of work area
☐ Improper Lifting, lowering or carrying technique	☐ Unsafe floors, ramps, stairways, platforms	☐ Inadequate job planning or worksite hazard analysis by supervisor
☐ Removed safety devices	☐ Poor housekeeping	☐ Lack of preventive maintenance
☐ Operating vehicle, equipment or machine at unsafe speed or unsafe manner	☐ Hazardous atmosphere: gases, dust, fumes, vapors or inadequate ventilation	☐ Unsafe design of equipment or work area
☐ Unaware of hazards or operating without authority	☐ Inadequate warning system	☐ Vehicle or equipment inspection process not adequate or not enforced
☐ Unsafe act of non-employee	☐ Limited visibility or adverse weather	☐ Employee insubordination or dishonesty or substance abuse
☐ Horseplay	☐ Poor road conditions	☐ Pre-existing physical condition
☐ Other-EXPLAIN:	☐ Other-EXPLAIN:	☐ Other-EXPLAIN:
☐	☐	☐
☐	☐	☐
☐	☐	☐

Using careless, hazard of job, and N/A are not acceptable investigation terms. Attach additional statements and reports.

ACTIONS

Direct Causes: WHAT ACTIONS WERE TAKEN TO REMOVE DIRECT CAUSES OR WHAT HAPPENED IN DEPARTMENT?	Who Completed this Action?	DATE COMPLETED
Basic Causes: WHAT ACTIONS WERE TAKEN TO REMOVE BASIC CAUSES? LIST ANY SAFETY PRACTICES THAT CAN BE PERFORMED TO HELP PREVENT REOCCURRENCE IN DEPARTMENT.	**Who Completed IT & WHO Affected in Department By these Corrective Actions**	**DATE COMPLETED**

Print Supervisor/Investigator Name	Supervisor Signature	Investigation Date	Date Notified of Accident

Department Accident Audit Checklist: (Complete within 48 hours or request 5 days extension. Email to Risk Management at rmclaims@horrycounty.org.)

Check Basic Procedures & Risk Management Standards Completed

☐Y ☐N Sent accident report to Risk Management within 24 hours.
☐Y ☐N Completed investigation
☐Y ☐N Completed corrective actions.
☐Y ☐N Sent copy of any employee medical restrictions to Risk Management and used light duty program to comply with restrictions from doctor if applicable.
☐Y ☐N Used designated doctor – Doctors Care.
☐Y ☐N ☐N/A Completed post-vehicle accident drug screen within 24 hours. Date: _____
☐Y ☐N ☐N/A Completed Driver alcohol screen within 2 hours. Date: _____
☐Y ☐N ☐N/A Took vehicle to Fleet Service or Fleet designated Body Shop within 24 hours (or next business day) Date completed

Supervisor Self Compliance Audit and Risk Management Checklist

1. Accident Date:	2. Accident Time:	☐ AM ☐ PM
3. Employee and/or Claimant Name:		
4. Date Notice of Accident Received by Supervisor or Supervisor-in-charge:		Within 24 Hrs? ☐ Y ☐ N
5. Investigation of All Causes Determined? ☐ Y ☐ N Describe causes/what happened.		
6. Confirm actual actions/corrections taken. What was done? What is the Status? Who benefited from the changes and how are similar accidents in your department prevented?		7. Dates Completed?
8. Designated Physician – Doctors Care Used? ☐ Yes ☐No		If not used, why not?
9. Light Duty Used: ☐ Yes ☐ No		10. Describe light duty assignment.
11. Audit requires Department Head, Asst. County Administrator, or County Administrator Signature:		12. Date Reviewed:

MEDICAL AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

TO ANY HOSPITAL OR DOCTOR CONCERNED:

The undersigned person hereby consents to and by this authorization or any photocopy thereof, hereby authorizes the release to my employer or any agent or designee of my employer and my employer's insurance carrier and/or third party administrator, of any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse of such patient.

The undersigned understands that my employer and its agents, designees and insurance carrier/third-party administrator, may from time to time, find it necessary to obtain information verbally from my treating health care providers and such contact is hereby authorized.

The undersigned person(s) understands and hereby acknowledges that the information above or certain portions thereof may be protected from disclosure without this signed authorization of federal and state privacy and confidentiality laws. A photocopy of this authorization will serve as an original.

ATTENTION MEDICAL PROVIDER **Send Medical Bills To**:

CorVel Corporation
PO Box 6966
Portland, OR

Email: 8888519190@onlinecapturecenter.com
Phone: 803-451-3401
Fax: 888-851-9190

Employer: Horry County Government
Workers' Compensation Carrier: South Carolina Association of Counties

ATTENTION EMPLOYEE:

Patient/Employee Name: _____

Type of Injury: _____ **Date of Injury**: _____

Employee SSN: _____ **Date of Birth**: _____

_____ _____
Patient/Employee Signature **Date**

ATTENTION SUPERVISOR:

This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. Authorization to seek treatment does not guarantee payment or that the claim will be accepted as compensable.

Supervisor Signature: _____

Printed Name: _____

Position/Title: _____ **Date**: _____

This form must be completed and given to the medical provider.