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

EMPLOYER (NAME & ADDRESS INCL ZIP)

Department Administration

CARRIER CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

LOCATION CODE

SIC CODE

EMPLOYER FEIN

-

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**