



2018-2019
Workers' Compensation
Claims Packet
And
Posting Notices

Report All Claims To:

Susan Kain
Workers Compensation Manager
skain@propelhr.com
Direct Line: (864) 679-6067
Direct Fax: (864) 335-4769



Important!

Workers' Compensation Claims Information

EMPLOYEE:

- Immediately notify the supervisor that a work-related injury or illness has occurred.
- Complete the "Injured Employee Accident Investigation Report" and give to supervisor.

SUPERVISOR:

- Assess the incident and assist the employee in seeking appropriate medical care or necessary treatment.
- Request a post-accident drug screening from the medical provider.
- Report the work-related injury, accident or illness within 24 hours to Propel HR by completing the "Supervisor's Incident Investigation Report."

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IMPORTANT! If an employee seeks medical treatment prior to reporting a work-related injury or illness to employer, medical expense reimbursement may be denied.

Supervisor's Incident Investigation Report

Employer Data

Company Name: _____
Company Address: _____
Phone: _____ FEIN #: _____

Employee Data

Employee Name: _____
Last *First* *M.I.*
Home Address: _____ Phone Number: _____
Job Title: _____ Social Security #: _____
 Part Time Exempt Rate of Pay: _____
 Full Time Hourly Pay Frequency: _____
Date of Hire (xx/xx/xxxx): _____ Date of Birth (xx/xx/xxxx): _____
Department: _____ Shift Hours: _____
What days does employee work? _____
Was employee paid in full for the date of injury? _____

Incident Data

Incident Date: _____ Time of incident: _____
Exact location of incident (including address): _____
Reported to whom
Date reported to Company: _____ (name, title, phone): _____
Did employee return to work? _____ Return date: _____
Brief description of injury/illness (burn, fracture, strain, cut, etc.): _____

Body part affected: _____
Did employee visit the doctor? _____ Date of doctor visit _____
Doctor's Name and/or Facility _____
List any witnesses: _____

Incident Details

Job or activity at time of incident _____

Describe clearly what occurred (How, when, where). Include diagram and pictures if needed.

Supervisor Information

Report Completed By: _____

Job Title: _____

Signature: _____

INJURED EMPLOYEE - ACCIDENT INVESTIGATION REPORT

TO BE COMPLETED BY EMPLOYEE This form is for reporting to management and may be submitted to the Insurance Company if petitioned to do so.

WHO WAS INJURED?	NAME _____ OCCUPATION _____ DEPARTMENT _____												
TIME AND PLACE	DATE _____ TIME _____ EXACT LOCATION _____												
DESCRIBE INJURY													
A DETAIL ACTIONS PRIOR AND UP TO INJURY. WHAT HAPPENED? USE REVERSE SIDE TO EXTEND COMMENTS													
B WHAT UNSAFE CONDITION (S) OR ACT (S) CAUSED THIS ACCIDENT?													
HOW CAN SIMILAR ACCIDENTS BE AVOIDED?													
WHAT ACTION HAVE YOU TAKEN TO PREVENT SIMILAR ACCIDENTS?													
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____</td> <td style="width: 50%; border: none;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">EMPLOYEE NAME-POSITION</td> <td style="border: none; text-align: center;">DATE</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">EMPLOYER NAME-POSITION</td> <td style="border: none; text-align: center;">DATE</td> </tr> <tr> <td colspan="2" style="border: none;"> EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED _____ </td> </tr> <tr> <td colspan="2" style="border: none; text-align: right;">DATE</td> </tr> </table>		_____	_____	EMPLOYEE NAME-POSITION	DATE	_____	_____	EMPLOYER NAME-POSITION	DATE	EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED _____		DATE	
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