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.

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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): ____________

Date reported to Company: ____________ Reported to whom (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:

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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: ____________________

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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?	

__________________ EMPLOYEE NAME-POSITION __________________ DATE

__________________ EMPLOYER NAME-POSITION __________________ DATE

EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED __________________ DATE