MARION COUNTY RISK MANAGEMENT
1305 North Main Street. PO Box 183 Marion, SC 29571
843-431-5009 (O) 843-430-7599(C) 843-423-8306(F)
Email: RM@marionsc.org

SUPERVISOR'S FIRST REPORT OF INJURY

(This report is to be completed by the Supervisor and forwarded to RM@marionsc.org within 24 hours of the employee being injured!)

1. EMPLOYEE INFORMATION:

Name:_____ _____ **SSN:** ### _-_ ## _-_____
(Last Name) (First Name) (Middle Initial)

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone #:_____ **Marital Status :** _____ **DOB:**_ _____ **Hire Date:**_____ __
(MM/DD/YYYY) (MM/YYYY)

Department:_ _____ **Phone #:**_____ **Position:** _____

Employee Status: F/T☐ P/T☐ Prisoner☐ Volunteer☐ Other: _____

Hours worked per pay period: _____ **Time shift started:** _____**AM ☐ PM ☐**_____

2. INJURY INFORMATION:

Date of injury:_ _____ **Time of Injury:**_____**AM☐PM☐**
(MM/DD/YYYY)
Last date worked:(If employee has not returned to work:)__ _____
(MM/DD/YYYY)
Location of accident:__ _____ **County Property: Yes☐ No☐**

Date employer notified:_____ **Individual notified:**_____
(MM/DD/YYYY)
Physician Name & Address:_ _____

Hospital Name & Address:_ _____

Phone #'s: Work:_ _____ **Home:**_____ _____

Date Returned to Work:_____ **Were safeguards or safety equipment provided? Yes☐ No☐**
(MM/DD/YYYY)
Were they used? Yes☐_ No☐

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3. Injury Details:
a. Describe nature of injury (include body part(s) affected; amputation of right index finger at 2d joint, fracture of arm below or above the elbow, burns, etc) (Continue on a separate page if necessary):
_____
_____
_____
_____

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b. Describe employees activities when injury occurred (include names of other individuals involved, tools, machinery, chemicals or unnatural motion(s) of employee - Give as much detail as possible) (Attach a separate page if necessary): _____
_____

4. Safety Equipment (PPE):
Was appropriate Safety equipment (PPE) used? (i.e., gloves, aprons, glasses, etc) Yes☐ No☐
Was appropriate PPE provided? Yes☐ No☐ If no, why wasn't the PPE provided

(The following questions apply only to the Detention Center, EMS, Fire District, Codes Enforcement, Environmental Services, Sheriff's Department and Building's Maintenance!)

Did this injury occur as result of an Infection Control Exposure Incident; either blood borne or airborne? Yes☐ No☐
Was an Infection Control Exposure Incident Report filed with the Department's Designated Officer in accordance with the Infection Control Plan? Yes☐ No☐

5. Medical Information/Treatment:
Did an EMS Service or a Volunteer Rescue Squad as a result of the accident transport the employee to a hospital? Yes☐No☐ If so what service or Rescue Squad transported the employee? (Please provide the Name of the Service or Squad and their address
Physician's Name and Address
Was the employee treated at a hospital? Yes☐ No☐ Was the employee hospitalized? YES ☐ NO☐
Which Hospital (Name and Address)

Was the employee treated: Emergency Room Yes☐ No☐
Out-patient Yes☐ No☐
First Aid: Yes☐ No☐
Did the employee refuse First Aid and/or medical care at the time of the accident or injury? YES ☐ NO ☐

If the answer is YES please have the employee sign here. _____

6. Notice of Communications with the Attending Physician: I understand that as a result and during the course of my illness or injury, Marion County will communicate with the attending physician to determine the following about my illness or injury; the causation of my illness or injury, the physician's diagnosis, the physician's recommended course of treatment, the physician's prognosis for my recovery, my ability to return to either light duty or full time duty and any work restrictions that the physician recommends.

_____ _____
Employee's Signature Date

Prepared by: _____ Date:_____
(MM/DD/YYYY)