SCDPS INCIDENT REPORT – Injury / Illness at Work

This form is to be completed by the affected employee and their supervisor as soon as possible after any injury/illness sustained at work, then forwarded to Human Resources. Report all injuries/illnesses at work to CompEndium as soon as possible at (877) 709-2667.

EMPLOYEE INFORMATION

Name of Employee: _____ Personnel #: _____

Division: SELECT ONE _____ Work Phone: _____ Personal Phone: _____

Date of Birth: _____ Marital Status: _____ Number of Dependents: _____

Home Address: _____

Does the employee have outside/dual employment? If so, where/what? _____

If outside/dual employment status is unknown at time of report, follow up with CompEndium after the initial report is made to notify them of employee's outside/dual employment status.

INCIDENT DESCRIPTION

Date/Time of incident: _____ AT _____ ○ AM ○ PM **Location of incident:** _____

Did the incident occur on SCDPS or State premises? ○ YES ○ NO

Hours of scheduled shift on date of incident: _____ AT _____ ○ AM ○ PM TO _____ AT _____ ○ AM ○ PM
Date *Start Time* *Date* *End Time*

Did the employee continue/complete their workday following the incident? ○ YES ○ NO

Date the employer was notified of incident: _____ Name of person notified: _____

Witnesses' names and phone #s: _____

Describe the nature of the injury/illness. Include symptoms and parts of the body affected. When applicable, specify right/left.

Describe the employee's activities at the time of the incident. Describe how the injury/illness was sustained.

What safety equipment was provided as a safeguard against this type of injury/illness? Was it utilized by the employee?

Did the employee lose consciousness for **any length of time** due to the incident? ○ YES ○ NO

Name/location of hospital, medical office, or clinic which administered treatment: _____

Highest level of treatment administered: ○ None ○ First Aid ○ ER/Outpatient Care ○ Inpatient Hospitalization

Reported to CompEndium by (supervisor): _____ _____ _____
Name Signature Date Reported

I, the affected employee, concur with the above statements. I understand that approval to work outside/dual employment is suspended during leave taken in relation to this incident and that approval may be reinstated contingent upon my medical release to return to work.

Injured Employee: _____ _____
Signature Date

south carolina DEPARTMENT of PUBLIC SAFETY
PROTECT. EDUCATE. SERVE.
10311 WILSON BLVD. // BLYTHEWOOD, SC 29016