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 at (877) 709-2667.

EMPLOYEE INFORMATION

Name of Employee: ____ Personnel #: ____

Division: ____________________________ 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 and how the injury/illness was sustained.

List safety equipment that 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.

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