

APPENDIX "B"

RICHLAND COUNTY

Supervisor's First Report Of Injury

Name (Last, First, M.I.)		Sex
Social Security Number	Home Phone	Date of Birth
Does the Employee Speak English? If No, Specify		
Race: White Black Asian	Ethnicity: Hispanic Native American Other	
Mailing Address (Street or PO Box)		
City, State, Zip		County
Marital Status	Married	Widowed Separated Single Divorced
# Dependent Children	Spouse's Name	
Doctor's Name (If doctor will be seen due to the injury)		
Doctor's Mailing Address (Street or PO Box)		
City, State, Zip		

Date of Injury	Time of Injury: am pm	Lost Time
Nature of Injury		Part of Body Injured
How and Why Injury Occurred		
Reg. Job? No	Yes	Worksite Location of Injury
Address Where Injury Occurred		
City, State, Zip		
Cause of Injury (fall, tool, machine, etc.)		
Witnesses? Please Name		
Return to Duty Date	Fatal? No	Yes Date Reported
Supervisor's Name		

Date of Hire	Length in Current Position Months	Years	Length in Occupation Years	Months	From MT? Yes No
Employee Classification Code		Occupation of Injured Worker			
Rate of Pay ____ Hourly \$____ Weekly	Full Work Week is: ____ Hours ____ Days	Last Paycheck Was: \$____ for ____ Hours or ____ Days	Is employee Owner? Yes No		

Name & Title of Person Completing Form	Name of Business
Business Mailing Address	Business Phone Number
City, State, Zip	Federal Tax Identification Number
Workmans' Compensation Insurance Company	Policy Number
Did the Injured Employee Request Accident Prevention Services in Past 12 Months? Yes No	
If Yes, Did He/She Receive Them?	
Signature & Title	Date