

**S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS**

EMPLOYER (NAME & ADDRESS INCL ZIP)  <b>YORK COUNTY RURAL FIRE PROGRAM</b>  <b>2151 ODGEN ROAD</b>  <b>ROCK HILL SC 29730</b>		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			LOCATION #
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			PHONE # <b>(803) 909-7620</b>
INDUSTRY CODE	EMPLOYER FEIN <b>576000418</b>				

**CARRIER/CLAIMS ADMINISTRATOR**

CARRIER (NAME, ADDRESS, & PHONE #) <b>Riverport Insurance Co.</b>  <b>PO Box 1918</b> <b>Columbia, SC 29202-1918</b> <b>(803) 252-1777</b>	POLICY PERIOD <b>10/1/2013</b>  TO <b>10/1/2014</b>	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) <b>Riverport Insurance Co.</b> <b>PO Box 1918</b> <b>Columbia, SC 29202-1918</b> <b>(803) 252-1777</b>
	CHECK IF APPROPRIATE  <input type="checkbox"/> SELF INSURANCE	

CARRIER FEIN <b>41-1654112</b>	POLICY/SELF-INSURED NUMBER <b>WC-39-84-011332-03</b>	ADMINISTRATOR FEIN
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AGENT NAME & CODE NUMBER <b>Correll Ins Group Inc</b>	<b>I - 199482463</b>
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**EMPLOYEE/WAGE**

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**OCCURRENCE/TREATMENT**

TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM ( <input type="checkbox"/> ) CANNOT BE DETERMINED	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL				CAUSE OF INJURY CODE	

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 <input type="checkbox"/> NO MEDICAL TREATMENT 1 <input type="checkbox"/> MINOR: BY EMPLOYER 2 <input type="checkbox"/> MINOR CLINIC/HOSP 3 <input type="checkbox"/> EMERGENCY CARE 4 <input type="checkbox"/> HOSPITALIZED > 24 HOURS 5 <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

**OTHER**

WITNESSES (NAME & PHONE #)			
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DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
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# ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Glatfelter Claims Management, Inc.  
P.O. Box 5126, York, PA 17405-9792  
(800) 233-1957, Fax: (717)747-7051

**PLEASE COMPLETE THIS FORM  
IN FULL FOR PROMPT SERVICE**

NOTE: Important State Information Included

DATE OF THIS REPORT \_\_\_\_\_

## SECTION 1 – CLAIMANT INFORMATION

*To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.*

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Name of Spouse (if applicable) \_\_\_\_\_  
Date of Incident or Organization's Activity \_\_\_\_\_ Year \_\_\_\_\_ Time \_\_\_\_\_  AM  PM  
Full-Time/Regular Occupation \_\_\_\_\_ Annual Income \_\_\_\_\_  
Name/Address of Full-time Employer \_\_\_\_\_  
Length of Employment in this Work \_\_\_\_\_ Employer's Phone Number \_\_\_\_\_

## SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?  
\_\_\_\_\_
2. How did the injury or illness occur?  
\_\_\_\_\_
3. Please describe the injury or illness.  
\_\_\_\_\_
4. Date of first day of full-time occupation missed due to above injury or illness (if applicable) \_\_\_\_\_ N/A
5. Date able to return to work (if applicable) \_\_\_\_\_ N/A
6. Attending Physician's Name, Address and Telephone Number \_\_\_\_\_
7. Name and Address of Hospital \_\_\_\_\_
8. Date Hospitalized From \_\_\_\_\_ To \_\_\_\_\_

## SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish Glatfelter Claims Management, Inc. with information or documentation they may request regarding details of the medical history and physical condition, current course of medical treatment or workers' compensation claim for the individual identified above. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

## SECTION 4 – CERTIFICATION

*To be completed by official of named insured organization (must be other than injured person)*

- Was the injured person a member of your organization at the time of the above described incident?  Yes  No
- If claimant is a member of organization, please select type of member:  Junior  Adult  Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization?  Yes  No
- **Name and Address of Organization** \_\_\_\_\_
  - Policy Number \_\_\_\_\_
  - Organization Telephone Number \_\_\_\_\_
  - Home Telephone Number of Official Signing Below \_\_\_\_\_

I certify that the above is true.

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

# York County Incident Investigation Report

1. Entity <b>YORK COUNTY</b>		2. Department	
3. Exact Location	4. Date of Occurrence	5. Time	6. Date Reported
INJURY OR ILLNESS		PROPERTY DAMAGE	
7. Injured's Name		12. Property Damaged	
8. Occupation	9. Part of Body Affected	13. Estimated Costs	14. Actual Costs
10. Nature of Injury/Illness		15. Nature of Damage	
11. Object/Equipment/Substance Inflicting		16. Object/Equipment/Substance Inflicting	
D E S C R I P T I O N	17. Describe Clearly How The Incident Occurred		
18. Witness			19. Telephone