

**University of South Carolina**  
**Workers' Compensation**  
**Supervisor Report** 

Name of Employee: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

How did the accident happen?

Has the employee completed an Employee Injury Report?  Yes  No

I have read the employee injury report and agree with the employee's statements.  Yes  No

If no, explain:

Were safeguards provided?  Yes  No  N/A  
If yes, describe safeguard (goggles, gloves, seat belts):

Was the employee using the safeguards?  Yes  No  N/A

How did you learn of this injury?  I saw the accident happen  Another employee told me  
 The employee told me of the injury.  Other \_\_\_\_\_

Did the employee return to work?  Yes  No If yes, what date? \_\_\_\_\_

Do you have restricted duty available?  Yes  No

Please print name \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_ Date signed \_\_\_\_\_

**NOTE: Send this form immediately to the Benefits Office, 1600 Hampton St., Columbia, SC 29208**

**Supervisor's Notes:**

**Original to Benefits Office and maintain a copy in department files.**