Reset Form

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.