|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employee Information |  | | |  |
| Last Name | First Name | | | Social Security Number |
| Click here to enter text. | Click here to enter text. | | | Click here to enter text. |
| School/Department | Position | | | DOB |
| Click here to enter text. | Click here to enter text. | | | Click here to enter text. |
| Home Address | | | | Home Phone |
| Click here to enter text. | | | | Click here to enter text. |
| Time of Injury |  | | | Date of Injury |
| Click here to enter text. | AM  PM | | | Click here to enter text. |
| Time Injury Reported |  | | | DateInjuryReported |
| Click here to enter text. | AM  PM | | |  |
| Exactly where on the property did the accident occur? Click here to enter text. | | | | |
| Describe the Accident: Click here to enter text. | | | | |
| List body part(s) injured: Click here to enter text. | | | | |
| What job-related activity was the employee performing at the time of the injury? Click here to enter text. | | | | |
| Identify what caused the accident. | | | | |
| 1. Was accident the result of an unsafe act?  Yes  No | | | | |
| 1. Was accident the result of a hazard?  Yes  No | | | | |
| 1. Describe the hazard or unsafe act: | | | | |
| List the names of all witnesses.  Click here to enter text. | | | | |
| IF MEDICAL TREATMENT IS SOUGHT, AN APPROVED PANEL PHYSICIAN MUST BE UTILIZED. | | | | |
| Left Work Due to Injury?  Yes  No | | Sent for Medical Treatment?  Yes  No | | |
| Taken via Ambulance?  Yes  No | |  | | |
| Name of Treating Physician: Click here to enter text. | | | | |
| Name of Hospital: Click here to enter text.  As the School Administrator, I do  do not  approve this as a Workers’ Compensation claim. *Initial Here \_\_\_\_\_* | | | | |
| Employee’s Signature: *(digital signatures are not accepted)* | | | Date: | |
|  | | |  | |
| Administrator’s Signature: *(digital signatures are not accepted)* | | | Date: | |
|  | | |  | |

**Supervisor’s On-Site Accident Reporting Procedures**

Please read all instructions before completing this report.

### In the case of a life threatening injury, call 911 or seek medical attention immediately.

1. **An accident form should be completed on ALL accidents.**
2. If medical treatment is **not** needed, fill out the accident form and email to

[chris parker@pickenscountyschools.org](mailto:sandylayman@pickenscountyschools.org?subject=Accident%20Report) . Keep a copy for your records.

1. If medical treatment **is** needed, call Chris Parker, fill out the accident form, and email to

[chrisparker@pickenscountyschools.org](mailto:chrisparker@pickenscountyschools.org?subject=Accident%20Report)[.](mailto:sandylayman@pickenscountyschools.org) Keep a copy for your records.

1. If medical treatment is sought, an approved panel physician must be utilized.   
   Please see panel.
2. Complete the **Accident Report Form** in its entirety within **24** hours of injury.
3. The accident form must be signed by a **building administrator**.
4. Failure to complete the **Accident Report Form** could lead to significant delays and denial of the claim.
5. **All claims submitted to Workers’ Compensation are subject to approval and investigation.**
6. The Pickens County School District will explore all claims submitted to   
   Workers’ Compensation.

*\*If you have further questions or concerns, please contact Chris Parker*

*@706-972-6595*