

**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 _____

Supervisor's Notes:

Fax this form immediately to Compendium Services at 1-877-710-2667 and maintain a copy in department files.