WORKERS' COMPENSATION

WHO IS ELIGIBLE

If an injury occurs on the job, performing duties within the scope of your position, you are covered under workers' compensation. This applies to anyone on Charleston Southern University's payroll including student employees.

WHAT TO DO

If an injury occurs please follow these procedures:

Non serious injury: If the injury is not serious, the employee should complete the attached "First Injury Report" form (additional copy can be found on the ADP portal), and bring it to the HR/Payroll Office before going to the doctor. The HR/Payroll Office will provide employee with an "Employer Authorization Form," which employee should give to Doctors Care so that any treatments are billed directly to the Worker's Compensation Insurance Company. **Doctors Care may bill employee's own medical insurance if they do not have the Employer Authorization Form, and employee will need to submit paperwork to the worker's compensation insurance company in order to be compensated for this.**

Serious or life threatening injury: If the injury is serious or life threatening, the employee should call 911 or be transported to the nearest emergency room. The supervisor should contact the HR/Payroll Office to advise of the injury, and complete the First Injury Report if facts are known.

****IT IS IMPORTANT TO FILL OUT THE FIRST REPORT OF INJURY TO ENSURE THERE ARE NO DELAYS IN PAYING THE MEDICAL BILLS ****

Once treated for injury, the employee will need to submit all paperwork received from Doctors Care or hospital to the HR/Payroll Office for workers compensation purposes.

DOCTORS CARE
8091 Rivers Avenue
North Charleston, SC 29406
(843) 572-7000
(Off Greenridge in the plaza next to Arby's)
Hours: 8:00 a.m. - 8:00 p.m. Monday - Friday
8:00 a.m. - 5:00 p.m. Saturday - Sunday

Directions from CSU: Turn left onto 78 then right onto Hwy 52 (Rivers Avenue). Travel approx. 1 mile on Rivers and take a right at the second traffic light onto Greenridge Road. Take the first left to the location.

CHARLESTON SOUTHERN UNIVERSITY

FIRST INJURY REPORT

Employee Name (Last, First, MI):	**DOB**:	**Time of Incident**:	**Date of Incident**:
Department:	**Job Title**:	Hire Date:	
Supervisor Name and Number:	**Employee Work Phone**: **Employee Cell Phone**:	**Employees Regular Work Hours** (Circle): **Days**: M T W T F S S **Hours**	

Name/Phone Number of any witness:	**List any witness who saw what took place**
WHAT HAPPENED?	**Describe what took place or what caused you to make this investigation.**
WHERE DID IT HAPPEN?	**State the building/location where incident occurred**
WHAT, IF ANY, INJURIES WERE SUSTAINED?	**Describe any injury you may have sustained**
DO YOU THINK ANYTHING COULD HAVE PREVENTED THE ACCIDENT?	

By signing below, you certify that the information contained herein is a true and accurate statement. **Employee Signature**	**Date**	**Reviewed by Human Resources (Sign)**	**Date**

BRING COMPLETED FORM TO THE HR OFFICE AS SOON AS POSSIBLE AFTER THE INCIDENT