

ACORD™ WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP) Pickens County 222 McDaniel Ave., B-14 Pickens, SC 29671		CARRIER CLAIM NUMBER	REPORT PURPOSE CODE
DEPARTMENT # (SEE BACK)		JURISDICTION	JURISDICTION CLAIM NUMBER
SIC CODE		LOCATION CODE	
EMPLOYER FEIN 57-6000395	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	PHONE #	

CARRIER/CLAIMS ADMINISTRATOR		CARRIER (NAME, ADDRESS & PHONE NO) Association of Counties P.O. Box 8207 Columbia, SC 29202		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO) Companion Property & Casualty Insurance Company P.O. Box 100159 Columbia, SC 29202 (800) 922-1282 FAX: 1-800-290-1858
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN		CHECK IF APPLICABLE <input type="checkbox"/> SELF INSURANCE	
AGENT NAME & CODE NUMBER					

EMPLOYEE/WAGE		NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL. ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		OCCUPATION/JOB TITLE	VOLUNTEER <input type="checkbox"/> YES <input type="checkbox"/> NO	
PHONE # (H) (W)	# OF DEPENDENTS	EMPLOYMENT STATUS <input type="checkbox"/> F/T <input type="checkbox"/> P/T		NCCI CLASS CODE		INMATE <input type="checkbox"/> YES <input type="checkbox"/> NO	
RATE PER	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

OCCURRENCE/TREATMENT		TIME EMPLOYEE BEGAN WORK: <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/SUPERVISOR/PHONE NUMBER		TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		WILL EMPLOYER PROVIDE MODIFIED DUTY, IF NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO			PART OF BODY AFFECTED		
DEPARTMENT OR LOCATON WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OF SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.						CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR-BY EMPLOYER <input type="checkbox"/> MINOR CLINIC HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED	
Panel Physician Utilized? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			WITNESSES (NAME & PHONE #)				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE				PHONE NUMBER () -	