S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
YORK COUNTY RURAL FIRE PROGRAM
PO BOX 82
YORK,SC 29745-0082

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

INDUSTRY CODE: 922160
EMPLOYER FEIN: 57-6000418

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)
Accident Fund Insurance Company of America
PO Box 40767
Lansing MI, 48901-7967
866-221-9640

POLICY PERIOD: 10/01/2019 TO 10/01/2020

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Accident Fund Insurance Company of America
PO Box 40767
Lansing MI, 48901-7967
866-221-9640

CARRIER FEIN: 38-3207001
POLICY/SELF-INSURED NUMBER: ARP12002962100
ADMINISTRATOR FEIN: 38-3207001

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
☐ Male
☐ Female
☐ Unknown

MARITAL STATUS
☐ Unmarried/Single/Divorced
☐ Married
☐ Separated
☐ Unknown

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

PHONE

OF DEPENDENTS

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM (☐) CANNOT BE DETERMINED ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED / DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION 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 OR 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? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 ☐	NO MEDICAL TREATMENT
1 ☐	MINOR: BY EMPLOYER
2 ☐	MINOR CLINIC/HOSP
3 ☐	EMERGENCY CARE
4 ☐	HOSPITALIZED > 24 HOURS
5 ☐	FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Glatfelter Claims Management, Inc.
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957, Fax: (717)747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

NOTE: Important State Information Included

DATE OF THIS REPORT _____

SECTION 1 – CLAIMANT INFORMATION

To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.

Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Name _____ Soc. Sec. No. _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Weight _____ Height _____

Gender _____ Marital Status _____ Name of Spouse (if applicable) _____

Date of Incident or Organization's Activity _____ Year _____ Time _____ ☐ AM ☐ PM

Full-Time/Regular Occupation _____ Annual Income _____

Name/Address of Full-time Employer _____

Length of Employment in this Work _____ Employer's Phone Number _____

SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?

2. How did the injury or illness occur?

3. Please describe the injury or illness.

4. Date of first day of full-time occupation missed due to above injury or illness (if applicable) _____ N/A ☐
5. Date able to return to work (if applicable) _____ N/A ☐
6. Attending Physician's Name, Address and Telephone Number _____
7. Name and Address of Hospital _____
8. Date Hospitalized From _____ To _____

SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish Glatfelter Claims Management, Inc. with information or documentation they may request regarding details of the medical history and physical condition, current course of medical treatment or workers' compensation claim for the individual identified above. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin _____ Relationship _____ Date _____

SECTION 4 – CERTIFICATION

To be completed by official of named insured organization (must be other than injured person)

- Was the injured person a member of your organization at the time of the above described incident? ☐ Yes ☐ No
- If claimant is a member of organization, please select type of member: ☐ Junior ☐ Adult ☐ Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization? ☐ Yes ☐ No
- **Name and Address of Organization**

York County Rural Fire Program
PO Box 82
York, SC 29745-0082

- Policy Number _____
- Organization Telephone Number (803) 620-2270
- Home Telephone Number of Official Signing Below _____

I certify that the above is true.

Signed _____ Title _____ Date _____

York County
Incident Investigation Report

1. Entity YORK COUNTY		2. Department	
3. Exact Location	4. Date of Occurrence	5. Time	6. Date Reported
INJURY OR ILLNESS		**PROPERTY DAMAGE**	
7. Injured's Name		12. Property Damaged	
8. Occupation	9. Part of Body Affected	13. Estimated Costs	14. Actual Costs
10. Nature of Injury/Illness		15. Nature of Damage	
11. Object/Equipment/Substance Inflicting		16. Object/Equipment/Substance Inflicting	

DESCRIPTION	17. Describe Clearly How The Incident Occurred

18. Witness	**19. Telephone**

YORK COUNTY VOLUNTEER FIREFIGHTER

INJURY RELEASE FOLLOW UP FORM

CLAIM NUMBER: _____

NAME: _____

FIRE DEPT: _____

PERSONAL PHONE NUMBER: _____

EMAIL ADDRESS: _____

DATE OF INJURY: _____

MEDICAL RELEASE DATE: _____

York County Rural Fire Program
(York County Department of Fire Safety)
2500 McFarland Rd
PO Box 82
York, SC 29745-0082
803-620-2270 phone
803-620-2269 fax