WORKER'S COMPENSATION

INCIDENT NOTICE

Use this form if no injury is claimed and no medical treatment was needed. For occupational injuries requiring medical attention or lost work days, call the **Telephonic Claims Reporting System 1-877-656-RISK (7475)** immediately upon notification of the injury.

Date Incident Reported by Employee_____

Name of Injured Employee_____Office Phone #_____

Job Title_____

Date of Incident_____Time of Incident_____

Description of Incident (how, where, why?) _____

_____

_____

Type of Injury (cut, scrape, burn, etc.)_____

Place of Occurrence (provide address if possible)_____

Was First Aid administered at time of incident? Yes___ No____ What Type?_____

_____

Witnesses (provide names and contact numbers)_____

_____

Supervisor's Name_____Office Phone#_____

Person Completing Report_____

Office Phone #_____ Date Report Completed_____

This form should be kept as part of the employee's personnel file and a copy sent to SGSC Human Resources 912-260-4376 or hr@sgsc.edu.

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