EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
Pickens County 222 McDaniel Ave, B-14 Pickens, SC 29671	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN: 57-6000395			PHONE #: 864-898-5855

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Key Risk P.O. Box 49129 Greensboro, NC 27419 1-866-847-8872	CHECK IF APPROPRIATE ☐ SELF INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
	191112	

AGENT NAME & CODE NUMBER: Capstone

EMPLOYEE/WAGE **Department : _____ Dept #_____**

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	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	
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 ☐ PM (☐) CANNOT BE DETERMINED	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