NORTH CAROLINA DEPARTMENT OF TRANSPORTATION
SUPPLEMENTAL REPORT OF INJURY

IF FORM 19, FIRST REPORT OF INJURY, DID NOT SHOW THAT THE INJURED EMPLOYEE HAD RETURNED T WORK, THIS FORM 19-S, SUPPLEMENTAL REPORT OF INJURY, MUST BE COMPLETED AND FORWARDED IMMEDIATELY UPON THE RETURN TO WORK OF THE EMPLOYEE, OR UPON TERMINATION OF EMPLOYMENT, DEATH, OR RETIREMENT OF THE INJURED EMPLOYEE. SEND THE ORIGINAL COMPLETEI FORM TO THE WORKERS' COMP UNIT, SAFETY & LOSS CONTROL. ***ALL*** *QUESTIONS MUST BE FULLY ANSWERED. (PLEASE PRINT CLEARLY OR TYPE.)*

Employee

1. Employee Name _____ 2. Personnel # _____
3. Department Code _____ 4. Date of Injury _____
5. Nature of Injury _____

Return to Work

6. Date and time employee returned to work _____

	Yes	No	
7.	☐	☐	Was the employee transferred to another job due to restrictions?
8.	☐	☐	Was employee placed on modified duty? If yes, how long?
9.	☐	☐	Did the Injured return to work and then lose more time for the same injury? If yes, please explain.

Lost Work Days

Under the current North Carolina Workers' Compensation Act, there is a 7 calendar day waiting period where no compensation for time lost from work is allowed except when the injury results in disability for more than 21 calendar days. (The 7 calendar day waiting period begins the day after the injured employe receives medical treatment.) If the disability exceeds 21 calendar days, then compensation is allowed from the date of the disability.

10. Total number of calendar days off from work _____
11. As applicable, enter the number of days of each appropriate category from which the injured employee was paid during the 7 calendar day waiting period:
    _____ Days of Vacation ____ Days of Compensatory Time _____ Days of Sick Leav
    _____ Days of Administrative Leave _____ Days of Leave Without Pay
12. Total number of Lost Work Days _____

Medical Care

	Yes	No	
13.	☐	☐	Is this employee still receiving medical care? If yes, what is the estimated length of treatment?

14. Remarks _____

Supervisor

15. Supervisor's Name _____
16. Personnel # _____ 17. Supervisor Title _____
18. Signature _____ 19. Date _____