

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No. _____	
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EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

A. IDENTIFYING INFORMATION						
EMPLOYEE	Last Name _____	First Name _____	M.I. _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
Address _____			Phone Number _____		Social Security Number _____	
Employee E-mail _____						
EMPLOYER	Name _____		NAICS Code _____	Nature of Business (Trade, Transport, Mfg., etc.) _____		
Address _____			Phone Number _____		Employer FEIN _____	
Employer E-mail _____						
INSURER / SELF-INSURER	Name _____		Claims Office Address _____			
CLAIMS OFFICE	Name _____					
SBWC ID # (five digit no.) _____	Insurer/ Self-Insurer File # _____	Claims Office Phone _____		Claims Office E-mail _____		
EMPLOYMENT/WAGE	Date Hired by Employer _____	Job Classified Code No. _____	Number of Days Worked Per Week _____		Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month	
List Normally Scheduled Days Off _____						
INJURY/ILLNESS & MEDICAL	Date of Injury _____	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury _____	Date Employer Notified _____	Enter First Date Employee Failed to Work a Full Day _____	
Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness _____			Body Part Affected _____	
If Returned to Work, Give Date _____	Returned at what wage per Week _____	If Fatal, Enter Complete Date of Death _____	How Injury or Illness / Abnormal Health Condition Occurred _____			
Treating Physician (Name and Address) _____			Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs		Hospital / Treating Facility (Name and Address) _____	

Report Prepared By (Print or Type) _____	Telephone Number _____	Date of Report _____
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B. INCOME BENEFITS		
Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____ Weekly benefit: \$ _____	Date of disability: _____
Form WC-6 must be filed if weekly benefit is less than maximum		
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____		
BENEFITS ARE PAYABLE FROM _____ FOR: _____		
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.		
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.		

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION	
Previously Medical Only? <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefits will not be paid because: _____

D. MEDICAL ONLY INJURY <input type="checkbox"/> No disability paid or controverted		
(Insurer / Self-Insurer: Type or Print Name of Person Filing Form) _____	Signature _____	Date _____
Phone and Ext. _____	E-mail _____	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.**
Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwc.georgia.gov>

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