

GEORGIA STATE BOARD OF WORKERS' COMPENSATION						OSHA File No.		
A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE						Insurer File No.		
Employer		Employer Phone No.		Insurer/Self Insurer Name		TPA/Claims Office		
Address				Employer FEIN		TPA FEIN		
City		State/Zip		Nature of Business (Mfg., Trade, Transp., Etc.)		Address		
Employer Location Address (If Different)				City		State/Zip		
Place of Accident or Exposure (Address or Location)				Occupation		TPA/Claims Office Phone No.		
Employee Name (Last) (First) (Middle)				Date of Birth		County of Injury		
Address				Date of Injury		Employee Social Security Number		
City		State/Zip		Employee's Home Ph. #		Number of Dependents Including Spouse		
DO NOT WRITE IN THIS COLUMN								
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Time of Injury	Time Workday Began am () pm ()		Date Employer Notified		Insurer No.	
Date Hired		Did Employee Work the Next Day? <input type="checkbox"/> Yes <input type="checkbox"/> No		First Date Employee Failed to Work a Full Day	Did Employee Receive Full Pay for Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		SIC	
Hours Worked Per Day ()		Number of Days Worked Per Week ()	List Normally Scheduled Off Days		Wage Rate at Time of Injury or Disease Hour () Day()		Date of Birth	
Per Week ()				Week() Mo.()		Sex		
COMPLETE WAGE STATEMENT ON REVERSE: If employee is paid hourly, on commission or piecework basis, enter average weekly amount \$				If board, lodging, or other advantages were furnished, enter average weekly amount \$		County of Injury		
Did Injury/Illness Exposure Occur on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>				Type of Injury/Illness	Part of Body Affected		Employer Aware	
How Injury or Illness/Abnormal Health Condition Occurred.							Nature	
If Returned to Work, Give Date		Returned at What Wage _____ per Week		If Fatal: Give Date of Death			Body Part	
Treating Physician (Name and Address)				Initial Treatment <input type="checkbox"/> No Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 hrs. MCO Yes <input type="checkbox"/> No <input type="checkbox"/>		Hospital (Name & Address)		Cause
Report Prepared By (Print or Type)		Position		Telephone Number		Date of Report		
EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY								
B. FOR USE BY INSURER/SELF-INSURER								
Average weekly wage: \$ _____		Weekly benefit: \$ _____		Date of disability: _____		Date of first payment: _____		
Compensation paid: \$ _____		Penalty paid: \$ _____		Previously Medical Only Yes <input type="checkbox"/> No <input type="checkbox"/>				
BENEFITS ARE PAYABLE FROM _____ FOR:								
<input type="checkbox"/> Total/temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks								
Part of Body								
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.								
By _____ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)								
C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)								
Benefits will not be paid because:								
By _____ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)								

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).

ADDITIONAL INFORMATION WHEN CONTROVERTING:

Complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment, and write the name of the similar employee here: _____. Also use to establish wage loss for temporary partial disability payments.

WAGE STATEMENT SCHEDULE OF WEEKLY EARNINGS										
Week No.	(Year) Week		No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
	From Date	To Date			Meals	Lodging	Rent	Tips	All Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
Total										
Average Weekly Earnings										

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 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 through 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 the:

STATE BOARD OF WORKERS' COMPENSATION;
Toll Free Telephone **1-800-533-0682**
In Atlanta, (404) **656-3818**