WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No.	

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.	☐ Male ☐ Female	Date of Birth
Address			Phone Number		Social Security Number
			Employee E-mail		
EMPLOYER	Name: Valdosta State University		NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.): Education	
Address: 1500 N. Patterson Street, Valdosta, Georgia 31698			Phone Number: (229) 333-5690		Employer FEIN
			Employer E-mail: jshunt@valdosta.edu		
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: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month	
List Normally Scheduled Days Off					
INJURY/ILLNESS & MEDICAL	Date of Injury	Time of Injury ☐ am ☐ 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? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ 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: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)			

Report Prepared By (Print or Type)	Telephone Number	Date of Report

B. INCOME BENEFITS

Previously Medical Only ☐ Yes ☐ 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:

☐ Temporary total disability ☐ Temporary partial disability ☐ 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? ☐ Yes ☐ No | Benefits will not be paid because:

D. MEDICAL ONLY INJURY ☐ No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filling 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.sbwc.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