

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 _____

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.sbwbc.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).