GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OSHA File No.	
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	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 ☐ Female ☐	Time of Injury	Time Workday Began am (☐) pm (☐)	Date Employer Notified
Date Hired	Did Employee Work the Next Day? ☐ Yes ☐ No	First Date Employee Failed to Work a Full Day	Did Employee Receive Full Pay for Date of Injury? ☐ Yes ☐ No
Hours Worked Per Day ( ) Per Week ( )	Number of Days Worked Per Week ( )	List Normally Scheduled Off Days	Wage Rate at Time of Injury or Disease Hour (☐) Day(☐) Week(☐) Mo.(☐)
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 $	
Did Injury/Illness Exposure Occur on Employer's Premises? Yes☐ No☐		Type of Injury/Illness	Part of Body Affected
How Injury or Illness/Abnormal Health Condition Occurred.			
If Returned to Work, Give Date	Returned at What Wage _____ per Week	If Fatal: Give Date of Death	
Treating Physician (Name and Address)	Initial Treatment ☐ No Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐ Hospitalized > 24 hrs. MCO Yes☐ No☐	Hospital (Name & Address)	

SIC	
Date of Birth	
Sex	
County of Injury	
Employer Aware	
Nature	
Body Part	
Cause	
M.O.	
Controvert	
D. First	

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 ☐ No ☐

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ (Part of Body) for _____ weeks

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 From Date	To Date	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					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**
http://www.ganet.org/sbwc

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