

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No. 0005	Employee Last Name 0043	Employee First Name 0044	M.I. 0045	Social Security Number 0042	Date of Injury 0031
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male 0053	Birthdate	Phone Number	Employee E-mail
	<input type="checkbox"/> Female 0052	0052	0051	N/A
Address 0046 0047		City 0048	State 0049	Zip Code 0050
EMPLOYER	Name 0018	NAICS Code 0025	Nature of Business (Trade, Transport, Mfg., etc.) N/A	
	Address 0019 0020		Phone Number 0159	Employer FEIN 0016
City 0021		State 0022	Zip Code 0023	Employer E-mail N/A
INSURER / SELF-INSURER	Name 0007	Insurer/Self-Insurer FEIN 0006	Insurer/ Self-Insurer File # 0015	
	CLAIMS OFFICE		Name 0188	Claims Office FEIN # 0187
		Claims Office Phone 0137	Claims Office E-mail 0138	
SBWC ID# (five digit no.) N/A	Address 0010	City 0012	State 0013	Zip Code 0014
EMPLOYMENT/WAGE	Date Hired by Employer 0061	Job Classified Code No. 0059	Number of Days Worked Per Week 0064	Wage rate at time of Injury or Disease: 0062 0063
	Insurer Type Code N/A 0I - Insurer 0S-Self-insurer 0G-Guarantee Fund		List Normally Scheduled Days Off N/A Report on WC-6 if less than MAX	
INJURY/ILLNESS & MEDICAL	Time of Injury 0032	County of Injury 0118	Date Employer had knowledge of Initial Disability 0040	Enter First Date Employee Failed to Work a Full Day 0056
	Did Employee Receive Full Pay on Date of Injury? 0066	Did Injury/Illness Occur on Employer's premises? 0249	Type of Injury/Illness 0035	Body Part Affected 0036
How Injury or Illness / Abnormal Health Condition Occurred 0037				
Treating Physician (Name and Address) N/A		Initial Treatment Given: <input type="checkbox"/> None 0039 <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) N/A	If Returned to Work, Give Date: 0068 Returned at what wage N/A per Week If Fatal, Enter Complete Date of Death 0146 0057

Report Prepared By (Print or Type) N/A	Telephone Number N/A	Date of Report N/A
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B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	0074	Average Weekly Wage: \$ 0286	Weekly benefit: \$ 0134	Date of disability: 0056
Date of first Payment: 0192	Compensation paid: \$ 0086	or Date salary paid: 0273 0056		Penalty paid: \$ 0216/310
BENEFITS ARE PAYABLE FROM 0088 FOR: 0085				
0 Temporary total disability 0 Temporary partial disability 0 Permanent partial disability of 0084 % to 0083 for 0090 weeks				
UNTIL 0089 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

Benefits will not be paid because: 0198 0197

D. MEDICAL ONLY INJURY No disability paid or controverted **N/A**

(Insurer / Self-Insurer: Type or Print Name of Person Filing Form) EDI Trading Partner Registration	Signature	Date HDR1
Phone and Ext. EDI Trading Partner Registration	E-mail EDI Trading Partner Registration	