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

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No. 0005	FROI 00/04

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
0043, 0255	0044	0045	0053	0052

Address	Phone Number	Social Security Number
0046 0047 0048 0049 0050	0051	0042/0154
	Employee E-mail: N/A	

EMPLOYER

Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
0018	0025	N/A

Address	Phone Number	Employer FEIN
0019 0020 0021 0022 0023	0159	0016
	Employer E-mail: N/A	

INSURER / SELF-INSURER Name	Claims Office Address
0007 0006	0010 0011 0012 0013 0014
CLAIMS OFFICE Name: 0188 0187	

SBWC ID # (five digit no.)	Insurer/ Self-Insurer File #	Claims Office Phone	Claims Office E-mail
EDI Registration	0015	0137	0138

EMPLOYMENT/WAGE

Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease:
0061	0059	0064	0062 0063 ❑ per Hour ❑ per Day ❑ per Week ❑ per Month

List Normally Scheduled Days Off: N/A report on WC-6 if less than MAX

INJURY/ILLNESS & MEDICAL

Date of Injury	Time of Injury	County of Injury	Date Employer Had Knowledge	First Date Employee Failed to Work a Full Day
0031	0032 ❑ am ❑ pm	0118	0040	0056 Never changes

Did Employee Receive Full Pay on Date of Injury?	Did Injury/Illness Occur on Employer's premises?	Type of Injury/Illness	Body Part Affected
0066 ❑ Yes ❑ No	0249 ❑ Yes ❑ No	0035	0036

If Returned to Work, Give Date	Returned at what wage	If Fatal, Enter Complete Date of Death	How Injury or Illness / Abnormal Health Condition Occurred
0068	N/A per Week	0146 0057	0037

Treating Physician (Name and Address)	Initial Treatment Given:	Hospital / Treating Facility (Name and Address)
N/A	❑ None 0039 ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	N/A

Report Prepared By (Print or Type)	Telephone Number	Date of Report
N/A submitter EDI Registration	N/A	0040

B. INCOME BENEFITS

Previously Medical Only: 0074 (L) ❑ Yes ❑ No

Average Weekly Wage: $ 0062 Weekly benefit: $ 0134

Date of disability: 0056 or 0144

Form WC-6 must be filed if weekly benefit is less than maximum

Date of first Payment: 0192 Compensation paid: $ 0086 or Date salary paid: 0273 0056 Penalty paid: $ 0216=310/ 0215

BENEFITS ARE PAYABLE FROM 0088 FOR: 0085

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of 0084 % to 0036 for 0090 Weeks.

UNTIL 0089 0068 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?	Benefits will not be paid because:
0074 (L) ❑ Yes ❑ No	0198 0197

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

(Insurer / Self-Insurer: Type or Print Name of Person Filling Form)	Signature	Date
N/A submitter EDI Trading Partner Registration		0040

Phone and Ext.	E-mail