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

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAI	LURE	TO SUBI	MIT THIS RE	PORT TO	INSURER	IMMEDIA	TELY MA	Y RESUL	T IN PE	NALTY.	MUST BE	TYPED O	R PRI	NTED IN	BLAC	K INK.	
Board Claim No.			Employee Last Name				Employee Fir			st Name			M.I	M.I.		of Injury	
A. IDENTIF	FYIN	G INF	ORMATI	ON											ı		
EMPLOYEE	_	Male Female	Employee 2 mail														
Mailing Address						l	City				State	State Zip Code					
EMPLOYER	EMPLOYER Name						NAICS Code Nature of Busin					Business (T	ness (Trade, Transport, Mfg.,etc.)				
Mailing Address							Phone Number						Employer FEIN				
City State Zip Code						ode	Employer E-mail						I_				
INSURER / Name SELF-INSURER							Insurer/Self-Insurer FEIN					Insurer/ Self-Insurer File #					
CLAIMS OFFICE		Name	Name CI				ns Office FEIN # Claims			s Office Phone			Claims Office E-mail				
SBWC ID# (five digit no.)			Mailing Address				(City			State			Zip Code			
EMPLOYMENT/WAGE			Date Hired by Employer Job Classified Co			ied Code N	No. Number of Days Worked Per Week					Wage rate at time of Injury or Disease: per Day per Week					
Insurer Type Code □I – Insurer □S-Self-insurer □Group Fund					List 1	Normally Sc	heduled Da	Days Off						per Week per Month			
INJURY/ILLNESS & MEDICAL			f Injury	County of Injury			Date Empl Injury			yer had knowledge of			Enter First Date Employee Failed to Wo a Full Day				
Pay on Date of Injury? on Emp			Employer's pre	//Illness Occur oyer's premises? es				Body Part A			rt Affected	ffected					
How Injury or Illnes																	
Treating Physician (Name and Address) Initial Treatment Given:					n:	Hospital / Treating Facility (Name and Address)						teturned to Work, Give Date:					
				Minor: By Employer Minor: Clinical/Hospit						Retu		Returned	urned at what wage			per Week	
				☐ Emergency Room☐ Hospitalized > 24hrs						If Fatal, Enter Cor Date of Death			omplete				
Report Prepared By (Print or Type)								Telephone			Telephone N	Number			Date of Report		
D. D. INICO		DENE	TITO -	14/0.0		e:	<u> </u>	e									
Previously Medical	Only		FITS Fo										Da	te of disal	bility:		
☐ Yes ☐ No Average Weekly Wage: \$													Popalty paid: \$				
BENEFITS ARE		or Date salary paid: Penalty paid: \$															
☐ Temporary t			-			_	Perman	nent partial	disabili	ty of	%	to		f	or	weeks.	
UNTIL	FORM		WHEN	THE EMPLO	OYEE ACT	UALLY R	ETURNED	O TO WOF	RK WITH	HOUT RE	STRICTIO					NS REQUIRE	
□ C. NOT																	
Benefits will not be							<u> </u>										
D. MED	NC A	ONII	V IN III	V (N= 1:	James 14: 1			a.a.d/	- N. C. N. C.	AT b		I \					
D. MEDICAL ONLY INJURY (No indemnity benefit Insurer / Self-Insurer: Type or Print Name of Person Filing Form								Signature					Date				
							oignature	<u>.</u>							Date		
Phone Number							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

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct Insurance Company and their SBWC ID number.

Complete Section B, Co or D and file with the Board and send a copy of both sides of the form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-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.

If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

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

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