

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.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Phone Number	Employee E-mail
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Mailing Address	City	State	Zip Code
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EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
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Mailing Address	Phone Number	Employer FEIN
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City	State	Zip Code	Employer E-mail
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INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
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CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
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SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code
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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
Insurer Type Code		List Normally Scheduled Days Off		
<input type="checkbox"/> I - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> Group Fund				

INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
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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
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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)	If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death
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Report Prepared By (Print or Type)	Telephone Number	Date of Report
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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	Average Weekly Wage: \$ _____ Weekly benefit: \$ _____	Date of disability:
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

Benefits will not be paid because:

D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	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.sbcw.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).