

GEORGIA STATE BOARD OF WORKERS' COMPENSATION						OSHA File No.	
A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE						Insurer File No.	
Employer		Employer Phone No.		Insurer/Self Insurer Name		TPA/Claims Office CSC	
Address				Employer FEIN		TPA FEIN 25-1683279	
City		State/Zip		Nature of Business (Mfg., Trade, Transp., Etc.)		Address P.O. Box 191387	
Employer Location Address (If Different)				City		State/Zip	
Place of Accident or Exposure (Address or Location)				Job Classification Code		City Atlanta, GA 31119-1387	
Employee Name (Last) (First) (Middle)				Date of Birth		TPA/Claims Office Phone No. 888-590-9487 / FAX 888-590-9488	
Address				Date of Injury		County of Injury	
City		State/Zip		Employee's Home Ph. #		Number of Dependents Including Spouse	
DO NOT WRITE IN THIS COLUMN		Insurer No.		SIC		Date of Birth	
Male <input type="checkbox"/>		Female <input type="checkbox"/>		Time of Injury		Time Workday Began am ( <input type="checkbox"/> ) pm ( <input type="checkbox"/> )	
Date Hired		Did Employee Work the Next Day? <input type="checkbox"/> Yes <input type="checkbox"/> No		First Date Employee Failed to Work a Full Day		Date Employer Notified	
Did Employee Receive Full Pay for Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		SIC		Date of Birth		Sex	
Hours Worked Per Day ( )		Number of Days Worked Per Week ( )		List Normally Scheduled Off Days		Wage Rate at Time of Injury or Disease Hour ( <input type="checkbox"/> ) Day( <input type="checkbox"/> ) Week( <input type="checkbox"/> ) Mo.( <input type="checkbox"/> )	
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 <input type="checkbox"/> No <input type="checkbox"/>				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 <input type="checkbox"/> No Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 hrs. MCO Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Hospital (Name & Address)	
Report Prepared By (Print or Type)		Position		Telephone Number		Date of Report	
<b>EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY</b>							
<b>B. FOR USE BY INSURER/SELF-INSURER</b>							
Average weekly wage: \$ _____		Weekly benefit: \$ _____		Date of disability: _____		Date of first payment: _____	
Compensation paid: \$ _____		Penalty paid: \$ _____		Previously Medical Only Yes <input type="checkbox"/> No <input type="checkbox"/>			
BENEFITS ARE PAYABLE FROM _____				FOR: _____			
<input type="checkbox"/> Total/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. 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)							
<b>C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)</b>							
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 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.

<b>WAGE STATEMENT SCHEDULE OF WEEKLY EARNINGS</b>										
Week No.	_____ (Year) Week		No. of Days Worked	Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
	From Date	To Date			Meals	Lodging	Rent	Tips	All Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
<b>Total</b>										
<b>Average Weekly Earnings</b>										

**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