WC-1 GEORGIA STATE BOARD OF WORKERS' COMPENSATION
(7/92) EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
__ Payment for Lost time (Parts A and B)
__ Y __ N Was this originally Medical Only? _____
__ Controvert (Parts A and C) Insurer File Number

_____ (___)_____ _____
Employee's Name (First) (Middle) (Last) Employee's Phone Number
Social Security Number

_____ _____
Employee's Street Address City State ZIP Date of Injury

_____ _____
Employer Insurer

_____ _____
Address Address

_____ _____ City
County State ZIP Phone City State ZIP Phone

A. REPORT OF INJURY EMPLOYER: FILL OUT PART A AND SEND THIS FORM TO YOUR INSURER

1. What is the nature of the business? _____Specific Product?_____ 2. What is the employee's regular occupation? _____
3. What is the employee's sex? __M __F
4. How old was the employee on the date of injury? ____Years, Date of Birth _____
5. How many days per week did the employee work?_____ What is the wage rate? $_____ per_
6. Did the employee receive full pay for the date of injury? _ Y _ N
7. Did the employee return to work? _ Y _ N If so, date _____
8. What was the date of disability? _____
9. Where was the accident or exposure? _____ County _____ State
10. On what date did the employer become aware of the accident? _____
11. What part(s) of the employee's body affected? _____
12. What is the nature of the injury (burn, fracture, strain, etc.)?_____
13. Did the employee die as a result of the accident? Y__ N__ Date of Death _____
    If so, how many dependents are there? _____
14. How did the accident occur? _____

By _____
(Employer: Type or print and Sign) (Date) Phone

B1. PAYMENT OF BENEFITS

Benefits are being paid to this employee at the rate of $_____* per week based on an average weekly wage of $_____, payable from _____, 19__ for:
_____ total/temporary total disability

_____ temporary partial disability
_____ permanent partial disability of __% to _____ for __ weeks.
(part of body)

The date of the first check is _____, the amount is $_____, and this:

___ does not include a penalty.
___ does include a ___% penalty in the amount of $_____.

* File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

B2. SUSPENSION OF BENEFITS

Benefits will be suspended on _____, 19__ because:

__ 1) Employee returned to work on _____, 19__, without restrictions from the authorized treating physician.

__ 2) Employee returned to work on _____, 19__, with restrictions from the authorized treating physician, at pre-injury or higher rate of pay.

__ 3) Employee returned to work on _____, 19__, with restrictions from the authorized treating physician, at reduced pay of $_____ per week, and temporary partial disability benefits are shown in Part A of the attached form WC-2.

__ 4) Employee was able to return to work on _____, 19__, without restrictions from authorized treating physician and the employee is being given 10 days notice, and authorized treating physician's report is attached. [Board Rule 221]

C. NOTICE TO CONTROVERT

Benefits will not be paid because:

By _____
(Insurer/Self-Insurer: Type or Print and Sign) (Date) Phone

FOR ADDITIONAL INFORMATION

NOTICE TO EMPLOYER WITH WORKERS' COMPENSATION INSURANCE

When an injury occurs:

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 the information portion and Section A of this form immediately upon your knowledge of an injury, and send the WC-1 to your insurance company. FAILURE TO DO SO MAY RESULT IN A PENALTY. Do not send this to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company's claims office.
4. Report serious injuries immediately by telephone to your insurance company's claims department,
then file this form with your insurance company.

NOTICE TO INSURER/SELF-INSURER

1. Upon receipt of this form, check to see that it is complete and accurate. Complete any unanswered questions. Be sure your name as insurer is correct. The insurance company name as well as a service company name, if applicable, must be indicated.
2. If the case involves lost time, complete either Section B or Section C and mail the original to the Board and a copy to the employee within 21 days of the employer's knowledge of the injury. If the case does not involve lost time, stamp "medical only" at the bottom of this form, and keep it in your files if you are not controverting liability. If you are controverting liability, complete Section C and mail the original to the Board and a copy to the employee within 21 days of the employer's knowledge of the injury.
3. PENALTIES MAY BE ASSESSED IF THIS FORM IS FILED LATE.

NOTICE TO EMPLOYEE

1. Your employer is responsible for filling out this First Report of Injury when you are injured on the
job. Notify your employer immediately when you are injured so that, if workers' compensation
benefits are due, you will receive your workers' compensation benefits timely.
2. 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.
3. If Section C is completed, your claim of injury has been denied by your employer. If you disagree with this denial, you must file with the Board a form WC-14, Notice of Claim, within one
year of the accident.

For information, assistance, or to file forms, contact:

STATE BOARD OF WORKERS' COMPENSATION
Suite 1000-South Tower
One CNN Center
Atlanta, Georgia 30303-2788

Phone (404) 656-3818 in Atlanta or 1-800-533-0682
To obtain forms, call 1-800-533-0682 (in Atlanta, 656-3870)