

AUGUSTA STATE UNIVERSITY WORKERS' COMPENSATION FORM EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE							
Employer		Department		Employer Phone No.		Insurer/Self Insurer Name	
Address				City State/Zip			
Nature of Business (Mfg., Trade, Transp., Etc.)							
Place of Accident or Exposure (Address or Location)				County of Injury		Occupation	
Employee Name (Last) (First) (Middle)				Date of Birth		Employee Social Security Number	
Address				Date of Injury			
City State/Zip		Employee's Home Ph. #		Number of Dependents Including Spouse			
Male Female	Time of Injury	Time Workday Began am () pm ()		Date Employer Notified			
Date Hired		Did Employee Work the Next Day? Yes No		First Date Employee Failed to Work a Full Day		Did Employee Receive Full Pay for Date of Injury? Yes No	
Hours Worked Per Day ()	Number of Days Worked Per Week ()	List Normally Scheduled Off Days		Wage Rate at Time of Injury or Disease			
Per Week ()	Week ()			Hour () Day() Week() Mo.()			
Did Injury/Illness Exposure Occur on Employer's Premises?(List witnesses) Yes No			Type of Injury/Illness		Part of Body Affected		
How Injury or Illness/Abnormal Health Condition Occurred.					How was the employee transported to the Dr./ER? Ambulance Self Other_____		
If Returned to Work, Give Date		Returned at What Wage _____per Week		If Fatal: Give Date of Death			
Treating Physician (Name, Address, Area Code, & Phone No.)			Initial Treatment No Treatment Minor: By Employer Minor: Clinic/Hospital Emergency Care Hospitalized > 24 hrs. MCO Yes No		Hospital (Name, Address, Area Code, & Phone No.)		
Report Prepared By (Print or Type)		Position		Telephone Number		Date of Report	
EMPLOYERS FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY							
B. THIS SECTION TO BE COMPLETED BY PERSONNEL							
Average weekly wage: \$ _____ Weekly benefit: \$ _____ Date of disability: _____ Date of first payment: _____							
Compensation paid: \$ _____ Penalty paid: \$ _____ Previously Medical Only Yes No							
BENEFITS ARE PAYABLE FROM _____ FOR:							
Total/temporary total disability Temporary partial disability Permanent partial disability of _____ % to _____ for _____ weeks							
Part of Body							
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)							
C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION							
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).

