A.

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 ( ) Per Week ( )	Number of Days Worked Per Week ( )	List Normally Scheduled Off Days	Wage Rate at Time of Injury or Disease 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).

Form ASUWC-1 **Rev. Date 8/2001** **Employers First Report of Injury or Occupational Disease**

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

Your employer has enrolled with the certified Workers' Compensation Managed Care Organization (WC/MCO) listed below to provide all the necessary medical treatment for workers' compensation injuries. The effective date is shown below. If you had an injury prior to the effective date listed below you may continue to receive treatment from your current non-participating authorized physician until you elect to utilize the services of the WC/MCO.

Each employee will be furnished with a publication which explains in detail how to access the services of the WC/MCO and provides a complete list of the medical providers available. In addition, each employee will be given a wallet-sized card which contains information on the services of the WC/MCO including a 24-hour toll-free phone number with recorded messages of information on how to utilize these services.

NAME OF WC/MCO **AMERISYS**

MAILING ADDRESS **140 Alexandria Blvd, Suite H - Oviedo, Florida 32765**

GEOGRAPHICAL SERVICE AREA **Sixty(60) mile radius from the employer's location**

NAME OF CONTACT PERSON **Cheryl Gulasa RN (For WC/MCO questions)**

PHONE NUMBER OF CONTACT PERSON **800 752 0886 x 102**

ADDRESS OF CONTACT PERSON **140 Alexandria Blvd, Oviedo, FL 32765**

24-HOUR TOLL-FREE PHONE NUMBER **(to report injuries) 877 656 7475**
(once injury is reported call AmeriSys Triage) 800 900 1582 option 2

EFFECTIVE DATE OF WC/MCO **8/1/2002**

The insurance company providing coverage for this business under the Workers' Compensation Law is:

DOAS
Name

205 Jesse Hill Dr.
PMB 38198
Atlanta, GA 30334
address

404 656 6245 or 800 656 7475
phone

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

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