

GEORGIA STATE UNIVERSITY MODIFIED WC-1

**EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
 GEORGIA STATE BOARD OF WORKERS' COMPENSATION**

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY
 This form must be completed by the injured employee's supervisor
 Please submit completed form to the Georgia State University Department of Safety and Risk Management

Assigned WC Claim #:	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
EMPLOYEE IDENTIFYING INFORMATION					
EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Home Phone Number	Employee E-mail	
Home Address			City	State	Zip Code
EMPLOYER INFORMATION					
Georgia State University			Nature of Business University		
Department of Safety and Risk Management 75 Piedmont Ave, Suite 506 PO Box 3961 Atlanta, GA 30303-3961			Employer's WC Contact Phone Number 404-413-9547		Employer's Fax Number 404-413-9550
			Employer's Contact E-mail oanderson@gsu.edu		
INSURER / SELF-INSURER	Department of Administrative Services (DOAS)		Claims Office Address		Claims Office Phone Number
CLAIMS OFFICE	Risk Management Services Workers' Compensation Unit		200 Piedmont Ave SE Suite 1208 West Atlanta, GA 30334		404-656-6245
EMPLOYMENT/WAGE INFORMATION					
Exact Date Hired by Employer	Number of Days Worked Per Week		Employee Status		Wage Rate at Time of Injury/ Illness
Employee's Department Name	List Normally Scheduled Days Off		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary <input type="checkbox"/> Other		<input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month <input type="checkbox"/> per Year
Employee's Job Title					
INJURY/ILLNESS & MEDICAL INFORMATION					
Time employee workday started on day of injury <input type="checkbox"/> am <input type="checkbox"/> pm	Exact Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury		Date Employer Notified of Injury	Enter First Date Employee Failed to Work a Full Day
Location of Injury or Accident Specific Location of Injury or Accident (address, bldg, room, etc)					
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(s) Affected	
Duties being performed when incident occurred					
How Injury or Illness / Abnormal Health Condition Occurred					
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> First Aid Only <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
Report Prepared By (Injured Employee's Supervisor or Designee, Please print or type name)				Date of Report	
Email Address of Person Preparing Report			Telephone Number		

If you have questions, please contact the following:
 Mary Anderson, Occupational Health & Safety Officer, Department of Safety and Risk Management
 Email: oanderson@gsu.edu Phone: 404-413-9547 Fax: 404-413-9550