Georgia State University

Insurance & Risk Management

GEORGIA STATE UNIVERISTY 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 Insurance & Risk Management.

Assigned WC Claim #:	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

EMPLOYEE IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ 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 Insurance & 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: **risk@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	❑ Full-Time ❑ Part-Time ❑ Temporary ❑ Other	❑ per Hour ❑ per Day ❑ per Week ❑ per Month ❑ per Year
Employee's Job Title			

INJURY/ILLNESS & MEDICAL INFORMATION

Time employee workday started on day of injury ❑ am ❑ pm	Exact Time of Injury ❑ am ❑ pm	County of Injury	Time &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? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ 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: ❑ None ❑ First Aid Only ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ 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 and TITLE)	Date of Report

Signature of Person Preparing Report	Email Address and Telephone Number

Revision 12/17/2020