## WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

## GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Lest Name	Z==	AILURE				TO INSURE				JLT IN	PENAL	_	<del>,</del>				LACK INK.	
March   Promise   Process   Proces	Board Claim No. Emp		oloyee Last Name Er			Employ	nployee First Name			M.I.	SSN or Board Tracking # Date of Injury							
March   Promise   Process   Proces	A IDENTIF	VINC	INIT	DESAT	ON													
Semilar   Semi	A. IDENTIF	_			UN		Phone Nu	ımhor			- Fanal	F						
MAIGE Books	EMPLOYEE TO THE TOTAL PROPERTY OF THE PROPERTY																	
Color   State   Zip Code   Employer FEIN   Instruction   Instruction   Employer FEIN   Instruction   Instruction   Employer FEIN   Instruction	Address		City					State Zip Code										
INSURER / SELF-INSURER  CLAIMS OFFICE  SWYD D8 filter SP Claires Office FEN # Claires Office	EMPLOYER Name							NAICS Code N				Nature	ature of Business (Trade, Transport, Mfg., etc.)					
SUIRER   SELF-INSURER   SELF-INSURER   Claims Office FEIN #   Clai	Address							Phone Number						Employer FEIN				
CLAIMS OFFICE  SEVEN DEFINED AND COLORS OFFICE  SEVEN DEFINED AND	City				State	Zip Co	de	Employer E-mail										
CLIMS OFFICE  SWC ID# (five digit no.)  Address  Date Hired by Employer  EMPLOYMENT/WAGE  Date Hired by Employer    Job Classified Code No.			Name							Insurer/Self-Insurer FEIN				Insurer/ Self-Insurer File #				
Servic IDE (five sigh no.)	-		Name		Clai				Office FEIN# Claims Office Ph			Phone	one Claims C			ail		
Injury or Disease:   per Day   per Day   per Day   per Week   per Month   pe				Address	ddress				City				State		Zip C	Zip Code		
Injury or Disease:   per Day   per Day   per Day   per Week   per Month   pe			1 6	Date Hired by	Employer	Job Classifi	ed Code No.	e No. Number of Davs Worke				Per Week Wage rate			rate at time of	e at time of O per Hour		
Last Normally Scheduled Days Off   per Month	EMPLOYMEN	T/WAG	- 1	· · · · · · · · · · · · · · · · · · ·					Hamber of Days Worked Pe			- / - / / / / / / / / / / / / / / / / /					per Day	
Insurer   S-Self-insurer   Group Fund   Gr	Insurer Type Code	lormally Sch	cheduled Days Off															
Injury / Like S		S-Self-in	surer	☐ Group F	und	.	·							. 1		_	- '	
Date of first Payment:	INJURY/ILLNE	ss	Time of	Injury	_	County of Ir	njury					oyer had kn	owleage	of		Date Emp	ployee Falled to Work	
Pay on Dale of Injury?	& MEDICAL									İ				ł				
Treating Physician (Name and Address)	Did Employee Receive Full Did Injury/Illness Occur on Employer's premises?  Type of Injury/Illness Body Part Affected  Body Part Affected																	
None   Minor: Districtal/Hospital   Emergency Room   Minor: Clinical/Hospital   Emergency Room   Minor: Clinical/Hospital   Emergency Room   Minor: Districtal/Hospital   Emergency Room   Minor: Districtal/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital																		
None   Minor: Districtal/Hospital   Emergency Room   Minor: Clinical/Hospital   Emergency Room   Minor: Clinical/Hospital   Emergency Room   Minor: Districtal/Hospital   Emergency Room   Minor: Districtal/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital/Hospital	Treating Physician	/Nome on	d Addros	c)	Initial Tec	antment Giver		Woenital	/ Treating Es	cility (N	ame and	Address)						
Minor: Clinical/Hospital Energency Room   Hospitalized > 24hrs   Energency Room   Energency Room   Hospitalized > 24hrs   Energency Room   Energency Room   Hospitalized > 24hrs   Energency Room   Energency Room   Energency Room   Energency Room   Hospitalized > 24hrs   Energency Room   Energe	rreating r nysician (		If Re						turned to Work, Give Date:									
Report Prepared By (Print or Type)    Date of Death								_					Retu	eturned at what wage per Week				
B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum  Previously Medical Only Yes   No   Average Weekly Wage: \$ Weekly benefit: \$ Date of disability:  Date of first Payment: Compensation paid: Penalty paid: Penalty paid: Penalty paid: \$																		
Previously Medical Only   Yes   No   Average Weekly Wage: \$   Weekly benefit: \$   Date of disability:    Date of first Payment:   Compensation paid: \$   or Date salary paid:   Penalty paid: \$    BENEFITS ARE PAYABLE FROM   FOR:    Temporary total disability   Temporary partial disability   Permanent partial disability of   % to   for   weeks.  UNTIL   WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.  C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION  Benefits will not be paid because:  D. MEDICAL ONLY   No disability paid or controverted  Insurer / Self-Insurer. Type or Print Name of Person Filing Form   Signature   Date	Report Prepared By (Print or Type)							Telephone					e Numbe	umber Date of Report				
Previously Medical Only   Yes   No   Average Weekly Wage: \$   Weekly benefit: \$   Date of disability:    Date of first Payment:   Compensation paid: \$   or Date salary paid:   Penalty paid: \$    BENEFITS ARE PAYABLE FROM   FOR:    Temporary total disability   Temporary partial disability   Permanent partial disability of   % to   for   weeks.  UNTIL   WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.  C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION  Benefits will not be paid because:  D. MEDICAL ONLY   No disability paid or controverted  Insurer / Self-Insurer. Type or Print Name of Person Filing Form   Signature   Date																<u></u>		
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Date of first Payment: Compensation paid: or Date salary paid: Penalty paid: \$  BENEFITS ARE PAYABLE FROM FOR:  Temporary total disability Permanent partial disability % to for weeks.  UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.  C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION  Benefits will not be paid because:  D. MEDICAL ONLY No disability paid or controverted  Insurer / Self-Insurer: Type or Print Name of Person Filing Form Signature  Date	Previously Medical C	Only												Date of disability:				
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Temporary total disability	Date of first Payment: Compensation paid: \$ or Date salary paid: Penalty paid: \$																	
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Insurer / Self-Insurer: Type or Print Name of Person Filing Form Signature Date	Benefits will not be p	aid becau	ise:		*****													
Insurer / Self-Insurer: Type or Print Name of Person Filing Form Signature Date																		
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Phone and Ext. E-mail	Insurer / Self-Insure	er: Type o	r Print Na	ame of Persor	n Filing Form			Signature	1							Date		
l .	Phone and Ext.							E-mail									<b>Constitution</b>	

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
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).