EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

(Georgia)

INSTRUCTIONS:

The employer completes the top portion of this form immediately upon knowledge of injury or disease, and must submit the form to the insurance company or self-insurer claims office. The Insurer will then fill out the bottom portion of the form, and return a copy to the Employer for the employer's files, and one copy to the Employee (for information only – employee does not alter the form in any way).
Complete the form as follows:

A: To be completed by Employer:

1. Employer information (address, phone number, FEIN, Insurer/Self Insurer name);
2. Place of accident
3. Job Classification Code
4. Employee information (Name, address, phone number, date of birth, Social Security number, gender);
5. Date and time of injury
6. Date employer notified
7. Hours worked
8. Date Employee failed to work a full day, pay received, normally scheduled days off;
9. Employee wages
10. Where injury/illness occurred (employer's premises?), type of injury/illness, part of body affected;
11. How injury or illness occurred;
12. Date returned to work, at what wage; if fatal, give date of death;
13. Treating physician (name and address), Initial treatment, Hospital/Treating Facility (name and address);
14. Report prepared by (person preparing report – type or print name), Position, phone number;

B: To be completed by Insurer/Self-Insurer:

1. Average weekly wage, Weekly benefit, date of disability, date of first payment;
2. Compensation paid, Salary paid, Penalty paid, Previous Medical (yes or no);
3. Prepared by (type or print name of person filing form and sign and date), phone number and extension number.

C: This section is to be filled out by Insurer/Self-Insurer only if benefits will not be paid; list reason, and sign and date.

The appropriate Fraud Statement has been included on the form.