A.

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

OSHA File No.

Insurer File No.

Employer: **University of Georgia Employee Benefits Dept.**
Employer phone no.
Insurer/Self Insurer Name: **Dept. of Administrative Services**
TPA/Claims Office

Address: **Human Resources Building**
Employer FEIN
TPA FEIN

City: **Athens, GA 30602** State/Zip
Nature of business (Mfg., trade, transp., etc.)
Address

Employer location address (if different)
City State/Zip
City State/Zip

Place of accident or exposure (address or location)
Occupation
TPA/Claims Office Phone No.

Employee name (last, first, middle)
Date of birth
County of injury

Address
Date of injury
Employee SS #

City State/Zip
Employee's home phone
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 the 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
__________ per ☐ Hour ☐ Day
__________ per ☐ Week ☐ Mo.

COMPLETE WAGE STATEMENT ON REVERSE: If employee is paid hourly, on commission, or piecework basis, enter average weekly amount.

$ ____________________________

If board, lodging, or other advantages were furnished enter average weekly amount

$ ____________________________

Did injury/illness exposure occur on employer's premises? ☐ Yes ☐ No
Type of injury/illness
Part of body affected

How injury or illness/abnormal health condition occured

If returned to work, give date
Returned at what wage ____________ per week
If fatal, give date of death

Treating physician (name & address)

Initial treatment
☐ No treatment
☐ Minor: By employee
☐ Minor: Clinic/hospital
☐ Emergency care
☐ Hospitalized>24 hrs.

M C O
☐ Yes
☐ No

Hospital (name & address)

DO NOT WRITE IN THIS COLUMN
- Insurer No.
- SIC
- Date of birth
- Sex
- County of injury
- Employer aware
- Nature
- Body part
- Cause
- M.O.
- Controvert
- D. First

Report prepared by (print or type) (Supervisor's signature)
Position
Telephone number
Date of report

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

B. FOR USE BY INSURER/SELF INSURER

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 (over for additional information)

Benefits will not be paid because:

By ____
(Insurer/Self Insurer: Type of 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 per violation (O.C.G.A. •34-9-18 and •34-9-19).

The University of Georgia
Incident/Accident Report

Faculty ☐ Staff ☐ Student worker ☐ Student ☐

Name _________________________________ Incident Date ___________ Time _________ ☐ am ☐ pm

Department Number ____ SS# ___________ Age __ Sex _____ Home phone ________________

Dept. or shop ______________________________ Job title _________________________

*Incident/accident (check all that apply:

☐ Lifting/moving ☐ Burn ☐ Occupational exposure (chemical, radiation, etc.)
☐ Fall ☐ Eye injury ☐ Struck by/struck against
☐ Cut/puncture ☐ Animal bite ☐ Other (specify)____

*Where did incident happen? (Be specific: building, room #, hallway, laboratory, etc.)

*Details of incident. (Describe exactly what happened. What was the employee doing?)

Name(s) and phone # of any witness(es):

*Work time lost Day of incident ________hrs Total time: ________days _______ hrs

*What preventive measures will be (or have already been) taken to reduce the possibility of recurrence?

Supervisor's Name ___________________________________ Phone# ______________________________

2nd-Level name ______________________________________ Phone# _____________________________

Dept. address _______________________________________ City _______________________________

Supervisor's signature _____________________________ Date _______________________________

Revised 07/06

The University of Georgia

Workers' Compensation Payment Election Form

Date ______________________________

Injured employee ____

Social Security # ____

I was injured on the job on (date) __________ while working for the Department of ________________________ with The University of Georgia. If I have to lose any work time because of this injury, I request payment as follows (check one of the following):

☐ From my accumulated sick leave, and if necessary, from accumulated annual leave, before receiving Workers' Compensation benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive Workers' Compensation benefits if I am still unable to return to work.

☐ Workers' Compensation benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular bi-weekly installments.

☐ Accrued leave through this date: ____________. Afterwards, I would like to be paid Workers' Compensation benefits for loss of wages instead of full pay.

I understand that I am not eligible to received Workers' Compensation wages until I have been out of work for seven (7) days (which may include one weekend), with payments beginning on the eighth (8th) day.

____

Signature of injured employee as shown on payroll

I have carefully considered the decision I have made regarding compensation for lost work time because of this injury. By my signature above, I certify that I understand the decision I have indicated is irrevocable after the first payment is made (either Workers' Compensation or leave payment).

If an "X" or mark is used as the signature, two (2) witnesses are required.

(1) _________________________________

(2) _________________________________

Revised 4/93

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title D.O.A.S. Risk Management Services		
Address P.O. Box 38198		
City Atlanta,	State GA	Zip Code 30334

RE: Employee / Patient		
Last Name	First Name	M.I.
Social Security Number	Date of Injury	Birthdate

This document authorizes the release of only those medical records related to the injury which is the subject of this claim for workers' compensation benefits and may be required at any time during the pendency of the claim. The above-stated entity, facility or medical practitioner is authorized to release

information to **DEPARTMENT OF ADMINISTRATIVE SERVICES** in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

> "When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. Notwithstanding any other provisions of law to the contrary, when requested by the employer any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee."

> "When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse. Said release shall designate the provider and shall state that it will expire on the date of the hearing. If the employee refuses to provide a signed release for medical information as required by this subsection, any weekly income benefits being received by the employee shall be suspended and no hearing shall be scheduled at the request of the employee until such signed release is provided."

The patient completely releases the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. This release is in compliance with Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 CFR 164.512(1) which reads as follows: *The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault.* Anyone who receives information under this document receives the same under all protection of Federal and State law inuring to the patient.

This release shall expire in 90 days or upon written notice of revocation by the patient, whichever is later. If a hearing is pending, this release shall remain in effect until and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

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).