GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE

Male / Female	Birthdate	Phone Number	Employee E-mail

Address	City	State	Zip Code

EMPLOYER

Name	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)
HALL COUNTY BOARD OF EDUCATION	611110	EDUCATION

Address	Phone Number	Employer FEIN
711 GREEN STREET	770-534-1080	58-6000256

City	State	Zip Code	Employer E-mail
GAINESVILLE	GA	30501	CANDY.THOMAS@HALLCO.ORG

INSURER / SELF-INSURER

Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
HALL COUNTY BOARD OF ED	58-6000256	

CLAIMS OFFICE

Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
BRENTWOOD SERVICES	62-1482047	615-263-1738	KELLY.WHITE@BWOOD.COM

SBWC ID# (five digit no.)	Address	City	State	Zip Code
20466	P.O. BOX 1125	BRENTWOOD	TN	37024-1125

EMPLOYMENT/WAGE

Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: per Hour / per Day / per Week / per Month

Insurer Type Code: Insurer / S-Self-insurer / Group Fund	List Normally Scheduled Days Off
	SAT AND SUN

INJURY/ILLNESS & MEDICAL

Time of Injury (am / pm)	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
	HALL		

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 Affected

How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address)	Initial Treatment Given: None / Minor: By Employer / 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 (Print or Type)	Telephone Number	Date of Report

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: $ ________ 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
KELLY WHITE		

Phone and Ext.	E-mail
615-263-1738	KELLY.WHITE@BWOOD.COM

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

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).