*(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)*

# OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

## WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible. (See Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

**Dade BOE -**

| | | |
|---|---|---|
| **CHI Memorial Family Practice of Trenton** *(Family Medicine)* | 12978 North Main Street, Trenton, GA 30752 | 706.657.4183 |
| **Primary Health Care Center** *(Family Medicine)* | 13570 North Main Street, Trenton, GA 30752 | 706.657.7575 |
| **WorkForce Corporate Health** *(Occupational Medicine/Industrial Clinic)* | 1100 East 3rd Street g150, Chattanooga, TN 37403 | 423.778.4800 |
| **Center for Sports Medicine & Orthopedics** *(Orthopedic Surgery)* | 2415 McCallie Avenue, Chattanooga, TN 37404 | 423.624.2696 |
| **UT Erlanger Orthopedics** *(Orthopedic Surgery)* | 979 East 3rd Street c430, Chattanooga, TN 37403 | 423.624.6584 |
| **Physicians Care - East Ridge** *(Occupational Medicine/Industrial Clinic)* | 403 Mcbrien Road, Chattanooga, TN 37412 | 423.894.3589 |
| **Center for Family Medicine** *(General Practice)* | 111 North Pine Street, Trenton, GA 30752 | 706.657.3360 |
| **UT Family Practice Center** *(Family Medicine)* | 1100 East 3rd Street, Chattanooga, TN 37403 | 423.778.8837 |

(Additional doctors may be added on a separate sheet)

The insurance company providing coverage for this business under the Workers' Compensation Law is:

**GSBA**

**PO Box 465328, Lawrenceville, GA 30042 - (888) 245-4722**

**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).**

Date: 4/29/16 - WC-P1 (7/2006)

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

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: DADE COUNTY SCHOOLS | NAICS Code | Nature of Business (Trade, Transport, Mfg.,etc.) | |
| Address: 52 TRADITION LANE | | Phone Number: 706-657-4361 | | Employer FEIN |
| City: TRENTON | State: GA | Zip Code: 30752 | Employer E-mail | |
| **INSURER / SELF-INSURER** | Name | Insurer/Self-Insurer FEIN | Insurer/ Self-Insurer File # | |
| **CLAIMS OFFICE** | Name | Claims Office FEIN # | Claims Office Phone | Claims Office E-mail |
| SBWC ID# (five digit no.) | Address | City | State | Zip Code |

| | | | | |
|---|---|---|---|---|
| **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 ☐ I – Insurer ☐ S-Self-insurer ☐ Group Fund | List Normally Scheduled Days Off | | | |

| | | | | |
|---|---|---|---|---|
| **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 |
| 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:<br>Returned at what wage per Week<br>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 |
|---|---|---|
| Phone and Ext. | E-mail | |

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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).