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: AMERICAN PAYROLL AND BENEFITS I, LLC	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)
Address: PO BOX 189		Phone Number: 352-624-1999	Employer FEIN: 46-2047314
City: OCALA	State: FL / Zip Code: 34480	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 ❑ – 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: 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
Phone and Ext.	E-mail	

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).

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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