GSW WORKER'S COMPENSATION - EMPLOYEE'S FIRST REPORT OF INJURY:

Name Of Employee:____

Job Title: ____________________________ Dept./School: _____________________________

SS # ______________________ Male ☐ Or Female ☐ DOB: _____________ Age: _______

Employee's Home Address: ____

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Employee's Home Tel. No. __________________________ Work Tel. No. ______________________

Date Of Employment: ___________________________ Current Annual Rate: $_______________

Date Of Injury: __________________ Time Of Injury: _______ __ M. Time Workday Began: _____ __M.

Date & Time Of Day That Employee Discontinued Work: ____

Place Of Accident Or Exposure: ____

Describe How The Accident Or Exposure Occurred. State What Employee Was Doing When Injured.

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Describe The Injury Or Occupational Disease In Detail. Include The Source Of Injury And Indicate The Part of Body Affected:

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Was Employee Paid In Full For This Workday? Yes ☐ No ☐

Has Employee Returned To Work? Yes ☐ No ☐ If So, Date Returned______________________

Hrs. Worked: Day ____ Week ____ Normally Scheduled Off Days: ________________________

Name & Address Of Treating Physician/Hospital (If Applicable):

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Witnesses To Accident:

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Date Reported to Supervisor: ___________________________ ___________________________________

(Supervisor's Signature)

Date Form Received in Human Resources: ______________________

NOTE: This form should be sent to the GSW Human Resources Office within 2 days of a worker's compensation accident inasmuch as the GSW Human Resources Office is required to notify the insurance carrier within 5 days of notification of the accident. Otherwise, the State Board of Workers' Compensation may assess penalties against GSW: From $100 - $1,000. (1/877/656-7475) **(Rev. 4/2006)**