Was WC Office notified (fax or email)?
Yes_____ No_____

Employee Accident Report

Richmond County School System • Worker's Compensation - Benefits Department
864 Broad Street, Suite 208 • Augusta, Georgia 30901
Ph. 706-826-1305 / 706-826-1104 • Fax: 706-826-4622• wellsan@boe.richmond.k12.ga.us

**** Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony in the third degree and are therefore subject to penalties of up to $10,000 per violation (O.C.G.A. §34-9-18 and §34-9-19).

Personal Information:

Name: _____ SSN: _____ DOB: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile: _____ E-mail: _____

Employee Information:

Hire Date: ____/____/____ Substitute: Yes or No (circle one)

School/Department: _____ Position: _____

10 Month _____
11 Month _____
12 Month _____

Hours worked per day:_____
Full Time:_____
Part Time: _____

AccidentInformation:

Date of accident: ____/____/____ Date employer aware: ____/____/____

Time of accident: _____ am/pm (circle one) Time workday began: _____ am/pm (circle one)

Place of accident: _____

If not employer's premises, provide place of accident below: _____

_____

Describe how accident occurred - what employee was doing at the time of accident. **Specific Body Parts Injured (left OR right).**

_____

_____

_____

_____

AccidentInformationcontinued:

Was safety equipment needed? Yes ____ No____ If yes, was safety equipment provided? Yes or No (circle one)
Was employee wearing safety equipment? Yes or No (circle one) Were there any witnesses? Yes or No

Witness Name: _____

What could have been done to prevent this accident?

_____

_____

_____

First day employee failed to work ____/____/____

Medical treatment:

* Did you receive any type of first-aid @ your school/department? Y or N
* Did you want to see a doctor? Y or No. If so, which doctor? (must chose from WC list)_____
*What is the date and time of your appointment?_____

HOSPITALEMERGENCYROOMINFO

*Did the employee receive a life-threatening injury? Y or N If yes, you must receive prior authorization before the employee goes to an ER (otherwise WC will not pay the claim).
*For authorization: 706-826-1305 or 826-1278. Authorization for ER is required. Who gave authorization?_____
* Which hospital ER did we authorize treatment at?_____

Ifother than theinjuredemployee,whocompleted thisform? (print clearly)

Name: _____ Position: _____

Employee provided with: (Have employee initial each item to acknowledge receipt of the following)

____ Posted panel of physicians (employee cannot use a personal physician)
____Accident Report (must fill out both sides)
____ Employee knowledge form
____ Pharmacy packet (disperse **Only** if a doctor's appointment has been made)

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EmployeeSignature: _____

Administrator/SupervisorSignature REQUIRED: _____

Date: ___/___/___

An "Acknowledgement form" must be submitted with every Accident Report. Worker's Comp. #3 (Rev. 7 - 16)