CITY OF CLARKSTON
where possibilities grow

Supervisor's 1st REPORT OF WORK RELATED INJURY

The Supervisor or a designee of the *City of Clarkston* should investigate an incident thoroughly and as quickly as possible and present the following information to Human Resource no later than 24 hours following the employee's report of the injury. Supervisors must immediately direct employee to HR to be sent for medical care, drug and alcohol screening.

Employer: *City of Clarkston* **Department: _____**

Employee Name: _____

Employee ID No.:_____

Date of Birth: _____ **Age: _____** **Sex: _____**

Employee Home Address: _____

_____

Home/Cell Phone Number: _____Office Phone No.:_____

Occupation: _____ **Hire Date: _____**

Full Time ☐ or Part Time ☐ **Salary: _____ (per hour/week/ or month)**

Normal Work Hours: _____ to _____ **Hours Worked per Day: _____**

Is the employee employed with any employer other than the City of College Park? _____

If so, name of employer and phone number: _____

Date of Injury: _____ Time: _____ AM/PM Place of Occurrence: _____

_____

Part of Body Injured (e.g., Right Hand, Lower Back, Etc.)? _____

Type of Injury (e.g., burn, sprain, broken bone, etc.)? _____

How and why did the injury or exposure occur? Please describe possible contributing events, conditions or personal actions: _____

_____

_____

_____

_____

What was the employee doing at the time of the accident? Please be as specific as possible: _____

_____

List all witnesses to the incident and provide phone numbers where available:_____

_____

_____

Could this have been prevented? Yes ☐ **No** ☐ **If so, how?** _____

_____

Did the employee seek medical treatment? Yes ☐ **No** ☐

Name and Address of Treating Physician/ Hospital:_____

_____

Was emergency care required? Yes ☐ **No** ☐ **Ambulance Required? Yes** ☐ **No** ☐

Did the employee leave work because of the injury? Yes ☐ **No** ☐ **If yes, when?** _____ **AM/PM**

Did the employee work the next day following the injury? Yes ☐ **No** ☐

First day Employee failed to work a full day? _____ **If returned to work, date:** _____

If Employee has not returned to work, anticipated length of disability: _____

What are the employee's job duties? _____

_____

_____

_____

Please give a brief description of any physical requirements of the job: _____

_____

_____

***Supervisor Signature:** _____

***Telephone Number of Supervisor:** _____

***Department Head Signature**_____

Employee Signature: _____
(If possible)

Date Report Completed_____

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

PANEL OF PHYSICIANS

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.

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

TPA CorVel Corporation
Insurer Name

PO Box 898	**Duluth, GA 30096**	**(800) 275-8836**
Address		**Phone**

Physician's Names

Concentra Medical Centers
Occupational Medicine
1045 Sycamore Drive
Decatur, Ga 30033
(404) 501-4270

Atlanta Bone & Joint Specialists
Orthopedics/Orthopedic Surgery
2801 N Decatur, Ga 30033
(404) 296-5005

Georgia Eye Partners
Ophtalmology/Ophatl Surg
200 East Ponce De Leon, Ste. 200
Decatur, Ga 30030
(404) 298-5557

First Medical Care
Primary Care
2536 Lawrenceville Hwy
Decatur, Ga 30033
(770) 934-6832

Resurgens Orthopedics
Orthopedics/Orthopedic Surgery
487 Winn Way, Ste. 100
Decatur, Ga 30030
(770) 491-3003

Peachtree Immediate Care-Decatur
Urgent Care
1834 Clairmont Road Ste 100
Decatur, Ga 30033
(404) 834-4443

Caduceus USA
Urgent Care/Occupational Medicine
3975 Lawrenceville Hwy Ste. A
Tucker, Ga 30084
(770) 270-8112

DeKalb Surgical Associate
Surgery - General
2665 N Decatur Road, Ste 730
Decatur, Ga 3003
(404) 508-4320

(Additional doctors may be added on a separate sheet) The insurance company providing coverage for this business under the Workers' Compensation Law is:

City of Clarkston

736 Park North Blvd. Suite 120 Clarkston, Georgia 30021 — 404-296-6489

Address — Telephone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STTE BOARD OF WORKERS' COMPENSATION AT 4Q4.IH-3818 OR 1.-00..S33.ota2 OR VISIT htti,.://sbwc.geo1111a.gov

Willfully meking a false statementforlhe purpose ct obtaining ordelllring beneffls is a aime subject lo penalties otup to $10,000.00 per violation (0.C.G.A. § 34-9-18 and§ 34-9-19).

WC-P1 (7/2022)