ACCIDENT / INJURY REPORTING INSTRUCTIONS  
FOR  
GEORGIA STATE UNIVERSITY  

If an employee is injured, their supervisor or the supervisor’s designee should be immediately notified (but no later than 24 hours).

At Georgia State University, the injured employee's supervisor, or the supervisor's designee, is responsible for correctly reporting the injured employee's accident to the Workers' Compensation Claims Service and to the Department of Safety and Risk Management, at Georgia State University. See specific supervisor instructions below.

After an employee is injured, and requires medical attention outside of regular first aid treatment, the injured employee, must first call the AMERISYS Managed Care at 678-781-2828, or 800-900-1582, to obtain assistance with selecting an authorized treating physician. The supervisor may assist the employee. This must be done before seeking any medical treatment unless the injury requires immediate medical attention, or is life threatening.

If an employee requires immediate medical attention, as in a life threatening emergency situation, the employee should proceed to the nearest emergency medical care facility or call 9-911 for assistance.

Following an employee's emergency admission, service or procedure, the employee, or the employee's designated representative must notify AMERISYS, INC., Managed Care of their injury by calling 1-877-656-7475 or (1-877-656-RISK).

If the employee requires additional care after the initial emergency care, the employee must contact AMERISYS, INC., Managed Care at 1-877-656-7475 or (1-877-656-RISK), and speak to a Case Manager who will assist them in selecting an authorized treating physician. The authorized treating physician will then evaluate the employee's treatment plan and make further recommendations.

The employee is responsible for providing the supervisor with a doctor's status report, each and every time the employee is seen by a Workers' Compensation Physician. The supervisor is responsible for faxing a copy of the employee's status report to the Department of Safety and Risk Management (404-413-9550).

Note: A claim must be filed so that the injured employee's medical bills can be paid. Georgia State University's Workers' Compensation program is managed by a third party administrator. The University's Department of Safety and Risk Management coordinates the claims process. The supervisor of the injured employee, or their designated representative, is responsible for reporting the employee's injury correctly.

SUPERVISOR INSTRUCTIONS FOR REPORTING AN EMPLOYEE'S INJURY AND FOR FILING AN EMPLOYEE'S WORKERS' COMPENSATION CLAIM:

To initiate the process of reporting an accident and filing a Workers' Compensation Claim, the supervisor of the injured employee or the supervisor's designee should:

1. Assure that ALL of the blank (non-highlighted) cells contained on the Employer's First Report of Injury or Occupational Disease Form (page 3) are filled in.

2. Sign, date the form and provide both an office telephone number and E-mail address in the spaces provided.

3. Report the information contained on the Employer's First Report of Injury or Occupational Disease Form to the claims service by calling the toll free number: 1-877-656-7475. (Georgia State University's location code is 7206). NOTE: Injured employees are NOT to sign their own First Reports of Injury or Occupational Disease or to call it in to the toll free number.
4. Obtain a claim number from the claims service and write it in the block labeled **Assigned Workers Compensation Claim No.** on the completed **Employer’s First Report of Injury or Occupational Disease Form.** NOTE: This block is found at the top of the Form, just under the heading.

5. Obtain a signed and dated **Leave Election Form** (page 4) from the injured employee. This must be filled out when the First Report of Injury Form is filled out. This tells the Workers’ Compensation Insurance how the injured employee wants to be paid for any time they have to be away from work. Even if no time is missed from work, the First Report must be filled out.

6. Obtain a signed and dated **Witness Form** (page 5). If no one witnessed the accident, then the injured employee must fully fill it out, sign and date it, putting "NO WITNESS" at the bottom of the form. On this form, the accident should be fully described, including specific causal elements for the accident/injury, specific location where the accident occurred and time the accident occurred.

7. Provide the injured employee with a copy of the form on how to obtain prescriptions under the provisions of Workers’ Compensation Insurance (page 6)

8. Fax the signed and dated **Employer’s First Report of Injury, the Leave Election Form and the Witness Form** to the Department Of Safety and Risk Management (404-413-9550) to the attention of Brenda Pool.

9. Send the **ORIGINAL** signed and dated **Employer’s First Report of Injury or Occupational Disease Form, the Leave Election Form and the Witness Form**, to:

Brenda Hinds Pool, MSPH, CWCP CIH  
Occupational Health and Safety Officer  
Right To Know Coordinator  
Workers’ Compensation Administrator  
Department of Safety and Risk Management  
Georgia State University  
PO Box 3961  
75 Piedmont Ave., Suite 506  
Telephone: (404-413-9545)  
Fax: (404) 413-9550  
E-mail: SAFBHP@langate.gsu.edu

If assistance or additional information is required, please contact Brenda Hinds Pool, MSPH, CWCP CIH at numbers listed above.
GEORGIA STATE UNIVERSITY MODIFIED WC-1
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Assigned Workers Compensation Claim No.:

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

IDENTIFYING INFORMATION

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>☐ Male</th>
<th>☐ Female</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Street</td>
<td>Phone Number</td>
<td>Social Security Number</td>
<td>Employee E-mail</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EMPLOYER

Georgia State University

Nature of Business

University

EMPLOYEE'S DEPARTMENT NAME:

Department of Safety and Risk Management

33 Gilmer St., P. O. Box 3961

Atlanta, GA 30302 - 3961

Address

Employer's Workers' Compensation Contact Phone Number

(404) 413-9545

Employer's Workers' Compensation Contact FAX Number

(404) 413-9550

Employer Contact E-mail

SAFBHP@langate.gsu.edu

INSURER/SELF-INSURER

Name

Department of Administrative Services

Claims Office Address

200 Piedmont Ave., SE, Suite 1208 West,

ATLANTA, GA 30334

404-656-6245

CLAIMS OFFICE

Name

Risk Management Services / Workers' Compensation Unit

Claims Reporting Phone Number (toll free number) 1-877-656-7475

(Location Code 7206)

Specific location where employee was injured or accident occurred:

Date Hired by Employer

Number of Days Worked Per Week

Wage rate at time of injury or Disease:

☐ per Hour

☐ per Day

☐ per Week

☐ per Month

List Normally Scheduled Days Off

INJURY/ILLNESS & MEDICAL

Date of Injury

Time of Injury ☐ am ☐ pm

County of Injury

Date Employer Notified

Enter First Date Employee Failed to Work Full Day

Did Employee Receive Full Pay on Date of Injury?

☐ Yes ☐ No

Die Injury/Illness Occur on Employer's premises?

☐ Yes ☐ No

Type of injury/illness

Body Part Affected

If Returned to Work, Give Date

Returned at what wage per Week

If Fatal, Enter Date of Death

How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address)

Initial Treatment Given:

☐ None

☐ Minor: By Employer

☐ Minor: By Clinical/Hospital

☐ Emergency Room

☐ Hospitalized > 24hrs

Hospital / Treating Facility (Name and Address)

Report Prepared By (Injured Employee's Supervisor or designee), (Print or Type Signature)

Office Telephone Number

Date Report Signed

E-Mail Address Of Person Preparing Report:

IF YOU HAVE QUESTIONS PLEASE CONTACT ONE OF THE FOLLOWING: THE DEPARTMENT OF SAFETY AND RISK MANAGEMENT AT GEORGIA STATE UNIVERSITY (404-413-9545), THE DEPARTMENT OF ADMINISTRATIVE SERVICES (404-656-6245) OR THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818

GEORGIA STATE UNIVERSITY

MODIFIED FORM WC-1- EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

REVISION. 11/12/08

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LEAVE ELECTION MEMORANDUM

Date: ______________________

To: Georgia Department of Administrative Services, Risk Management Services
Workers’ Compensation Unit, 200 Piedmont Ave, SE, Suite 1208 West,
Atlanta, Georgia 30334

Co: Benefits Office of Human Resources, Georgia State University
University Plaza, Atlanta, Georgia 30303-3083

From: Safety and Risk Management, P.O. Box 3961, Georgia State University,
75 Piedmont Ave, Suite 506, Atlanta, Georgia 30302-3966

Re: Workers’ Compensation Payments for (Print Employee’s Name):

On the Date of ______________, I ______________________________ was injured on the
job while working for the Department of ____________________________ at Georgia State
University. If I lose any time because of this injury, I request that I be paid in the following
manner:

( ) From my accumulated sick leave, and ( ) from my accumulated vacation
leave before receiving Workers’ Compensation benefits for loss of wages.

( ) Workers’ Compensation benefits from the State of Georgia for loss of wages
instead of full pay from accumulated sick and vacation leave from my employer,
Georgia State University. I understand that I will be compensated at no more
than 66 2/3% of my wage.

( ) From my accumulated sick leave, and if necessary, from my accumulated
vacation leave from the date of _________ until the date of _________ after
which time I wish to be paid Workers’ Compensation benefits for loss wages.

_________________________________________               ______________
Signature of Employee (as shown on payroll)                      Date

GSU Human Resources completes this section.

The GSU Employee, _________________________________,
SSN: _______________________________ has a balance of
______ vacation hrs. and ______ sick leave hrs.
Leave will end as of _______________. Weekly Wage
Rate$________ Short Term Disability Enrollment________
Verified
by: _________________________________ Date ______

Page 4 of 6
ACCIDENT WITNESS STATEMENT
(To be completed by accident witness)

Injured employee’s name: ____________________________
Last First Middle

Name of witness: ____________________________
Last First Middle

Job title of witness: ____________________________
How long employed here?

Home address of witness: ____________________________

City: ____________________________ State: __ Zip Code: __________

Location of accident: ____________________________
Address/Name of building ____________________________ Area (bathroom, etc.)

Date of accident: ________________ Time of accident: ________________

Describe fully how accident occurred: (including events that occurred immediately before the accident):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe bodily injury sustained (be specific about body part(s) affected):

________________________________________________________________________

Recommendation on how to prevent this accident from recurring:

________________________________________________________________________

Name of Witness: ____________________________ Supervisor: ____________________________
Last First Ph# ____________________________

Signature of Witness: ____________________________ Date: ____________________________

State of Georgia
Department of Administrative Services – Risk Management Services
200 Piedmont Avenue S.E., Suite 1208, West Tower
Atlanta, Georgia 30334-9010
State of Georgia DOAS Workers’ Compensation
Temporary (first fill) Prescription Information

Injured Worker:
State of Georgia Department of Administrative Services, has partnered with myMatrixx to make filling workers’ compensation prescriptions easy!

This document serves as a temporary (first fill) prescription card. Prescription fills of injury-specific medications up to a three-day supply will be honored. After your claim is accepted, you may have the remainder of the prescription filled. A permanent prescription card specific to your injury will be forwarded directly to you within the next three to five business days.

Please take this letter and your prescription to a pharmacy near you. The myMatrixx pharmacy network consists of more than 50,000 pharmacies nationwide. If you would like to know if a specific pharmacy is in our network, please call (877) 804-4900.

If the pharmacy denies your medication, please call (877) 804-4900.

Pharmacist:

Please use this information when processing prescriptions for this patient’s workers’ compensation injury:

Patient Name: __________________________________________
Group #: 20012105
Member ID (SSN): ______________________________________
Date of Injury: _________________________________________
Processor: Matrixhcs
Bin#: 011073
Day supply is limited to three days for a new injury.
myMatrixx Help Desk: 877-804-4900

For questions or rejections, please call (877) 804-4900. Please do not send the patient home or have the patient pay for medication(s) before calling myMatrixx.

*Employer Authorized Signature and Phone #:
Brenda Hinds Pool – 404-413-9545

NOTE: State of Georgia DOAS has pre-approved certain medications for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS CALL: (877) 804-4900