

# UWG FIRST REPORT OF INJURY

Call University Police (678-839-6000) for immediate medical attention.

All injuries are to be reported to Risk Management. Fill out Section I of this form and send to RM/EHS via campus mail; or fax both sides of this document to 678-839-6635.

## **SECTION I.**

### Agency Information

Agency name: University of West Georgia Location code: 7256  
Address: 1601 Maple Street, Carrollton, GA 30118

### Incident Information

Date of incident: \_\_\_\_\_ Time: \_\_\_\_\_  
Date employer notified: \_\_\_\_\_ Time: \_\_\_\_\_  
Type of incident: Employee Injury

### Employee Information

Social security number\*: \_\_\_\_\_  
Name (first, MI, last): \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Male/Female: \_\_\_\_\_  
Marital status: \_\_\_\_\_ Number of dependents, including spouse: \_\_\_\_\_  
Job title: \_\_\_\_\_ Date of hire: \_\_\_\_\_  
Full time or part time?: \_\_\_\_\_ Hours per week: \_\_\_\_\_ Wage: \_\_\_\_\_ hr/wk/mo/yr  
(circle one)

### Supervisor Information

Supervisor Name: \_\_\_\_\_  
Supervisor Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Injury Information

What was the employee doing when the injury occurred? Where did it happen? \_\_\_\_\_

What happened? \_\_\_\_\_

What is the injury? \_\_\_\_\_

Names/phone #'s of witnesses to accident: \_\_\_\_\_

### Treatment Information

Where did employee go for treatment? \_\_\_\_\_

Address, phone of medical facility: \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Who drove employee? \_\_\_\_\_

\*Your social security number is necessary if you seek treatment for your injury. If you are uncomfortable providing this information on this form, you may provide it over the phone.

**Lost Time Information**

Did employee return to work following the incident? \_\_\_\_\_  
If employee sought treatment, did employee return to work following treatment? \_\_\_\_\_  
Is employee currently out of work? \_\_\_\_\_ First day employee did not work a full day: \_\_\_\_\_  
How much total time did the employee lose? \_\_\_\_\_

**Department Information**

Time workday began: \_\_\_\_\_  
Name of employee's department: \_\_\_\_\_  
Department phone: \_\_\_\_\_ Employee's email address: \_\_\_\_\_

**Supervisor's Section**

Did you discuss this incident with the employee? \_\_\_\_\_  
Recommendations for corrective actions: \_\_\_\_\_  
What can the University do to prevent this type of incident from happening again? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Supervisor Signature & Date:** \_\_\_\_\_

**SECTION 2.**

*If Risk Management is not available to assist, call 877-656-7475 to activate this claim.*

**Other Information**

Employee job classification number: \_\_\_\_\_ OSHA case number: **None**  
NAICS code: **611310** SBWC ID#: **20788**

**Follow-Up Information**

Claim number: **WC**  
DOAS caseworker/contact: \_\_\_\_\_  
MCO phone number: **678-781-2847**  
Agency contact: **Matt Jordan**  
Email: **safety@westga.edu** Fax: **678-839-6635**

**Risk Management Section**

*Caller Information*

Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Title: \_\_\_\_\_  
Agency address: **1601 Maple Street** ZIP: **30118** Tel: **678-839-6277**  
Other notes: \_\_\_\_\_

*Follow Up information* \_\_\_\_\_