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.: WC

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

IDENTIFYING INFORMATION

<table>
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<tr>
<th>EMPLOYEE</th>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Gender</th>
<th>Date of Birth</th>
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Address
Street
City    State    Zip Code

Home Phone Number

Employee E-mail

Employee's Job Title

EMPLOYER

Georgia State University

Address

Department of Safety and Risk Management
75 Piedmont, Suite 506, P. O. Box 3961
Atlanta, GA 30303 - 3961

Nature of Business

University

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: Contact Department of Safety and Risk Management – 404-413-9549 for assistance.

SPECIFIC location where employee was injured or accident occurred:

EXACT Date Hired by Employer

Month   Day   Year

Number of Days Worked Per Week

Wage rate at time of injury or Disease:

$ AMOUNT

per Hour

per Day

per Week

per Month

per Year

List Normally Scheduled Days Off

Employee's Job Title

INJURY/ILLNESS & MEDICAL

Date of Injury

EXACT Time of Injury

County of Injury

Date Employer Notified

Full Time Employee Failed to Work

Did Employee Receive Full Pay on Date of Injury?

Yes   No

Did Injury/Illness Occur on Employer's premises?

Yes   No

Type of injury/illness

Body Part(s) Affected

If Returned to Work, Give Date: Date: wage:

Returned at

per Week

what If Fatal, Enter Date of

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,

OCCUPATIONAL HEALTH AND SAFETY OFFICER, AT GEORGIA STATE UNIVERSITY (404-413-9545),

REVISION 02/10/17