Dexter Mills, Executive Director

3167 Cedartown Hwy SE • Rome • GA • 30161 • (706) 295-6189 • FAX (706) 295-6098
Toll Free (GA only): 1-800-404-4149

Workers' Compensation Packet

Employee's Report of Injury – This form should be completed by the injured employee – **in their own handwriting.** This form should be filled out immediately following any work-related accident or injury and faxed to Pamela Warren at 706-295-6069.

Supervisor's Report of Injury – The Supervisor should complete this report form as quickly as possible. Forward the completed form to the RESA office.

Witness Statement – A witness statement should be obtained from any adult who witnessed the accident. If there was more than one witness, a separate form should be completed by each witness. Copies of this form may be made on an as-needed basis. The supervisor will also sign the form for verification purposes. Forward the completed form to the RESA office.

Medical Content Form – This form should be completed as soon as possible following the accident or injury. The consent form also requires a witness signature. Forward the completed form to the RESA office.

***Attending Physician's Report** – This form should be completed by the attending physician at the time of medical treatment. The **Medical Release Form** which lists job duties must also be reviewed and signed by the attending physician. Forward both completed forms to the RESA office **BEFORE** returning to work.

Prescription Card – Medical prescriptions are covered by Preferred Medical Network. You will need to see your Area Administrator for a prescription card prior to seeking medical treatment. Contact Pamela Warren at 706-295-6189 ext. 22 for further instructions. Please return unused cards to your Area Administrator.

EMPLOYEE'S REPORT OF INJURY

(An injured employee should complete this form as soon as possible after an injury. Please answer ALL questions.)

Name:_____ SSN:_____ DOB:_____

Home Address:_____
(Mailing Address, including Zip Code)

Home Phone:_____ Work Phone:_____

Work Location:_____ Job Title:_____

Date of Injury:_____ Time of Injury:_____ Email Address:_____

Where did the accident happen?_____

Please tell in your own words exactly how the accident or injury occurred:

_____

_____

Who did you tell about your accident or injury?_____

Were there any witnesses?_____ If yes, please name:_____

Please list ALL parts of the body that were injured (BE SPECIFIC – note right and/or left where necessary):_____

_____

Did you seek medical treatment?_____ If so, where?_____

In your opinion, how could this accident or injury have been prevented?_____

_____

Are you employed with any other employer other than Northwest Georgia RESA or Northwest GNETS?_____

If so, please provide the employers name and a description of your job duties:_____

_____

_____

Employee Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

SUPERVISOR'S REPORT OF INJURY

Every work-related accident or injury should be investigated thoroughly and as quickly as possible. Please answer **ALL Questions.**

Name of Person Injured:_____ Date of Injury:_____

Home Address:_____

Home Phone:_____ Work Phone:_____

Job Title:_____ Work Location:_____

At what location did the accident or injury occur?_____

What time did the accident or injury occur?_____

When did you first become aware of the accident or injury?_____

Did the employee seek medical treatment?_____ If so, where?_____

What part(s) of the employee's body were injured? (Please be as detailed and specific as possible):

_____

_____

What is the nature of the injury (burn, fracture, strain, etc.):_____

Were there any witnesses to the accident or injury?_____ If yes, please name:_____

_____

Please describe in your own words how the accident/injury occurred. Be as detailed as possible. List any objects or circumstances either directly or indirectly related to the accident/injury. You may use the back of this form if necessary._____

_____

_____

In your opinion, how could this accident/injury have been prevented?_____

_____

_____

Supervisor Signature:_____ Date:_____

Director Signature:_____ Date:_____

WITNESS STATEMENT

Name of Injured Employee:_____

Name of Witness:_____ Phone:_____

Home Address:_____
(Mailing Address, including Zip Code)

Work Location:_____ Position:_____

How long have you known the injured employee?_____

Do you work directly with the injured employee?_____ For how long?_____

In what capacity do you work with the injured employee?_____

To the best of your knowledge, state the date and time you became aware of the accident or injury:

_____

_____

Did you see what happened?_____ If not, what do you believe was the cause of the accident / injury?

_____

What body parts appeared to be injured?_____

Who else saw the accident / injury or has knowledge of it?_____

Do you think the employee was injured?_____ Why?_____

_____

In your opinion, what caused this accident or injury?_____

_____

In your opinion, how could this accident or injury have been prevented?_____

_____

If you have any additional comments or information regarding this accident / injury, please list them on the back of this form.

_____

Witness Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

MEDICAL CONSENT FORM

I hereby authorize Northwest Georgia RESA and/or Northwest GNETS, including any and all of their representatives, as well as GSBA Worker's Compensation, and its representatives, to obtain and review any and all medical records generated as a result of my work-related accident and injury. I also grant permission to allow any of the above companies or individuals to discuss my diagnosis and treatment with any physicians or other professionals involved in my treatment resulting from my work-related injury.

I agree that a photocopy or fax copy of this signed authorization shall be as valid as an original.

Signed:_____ Date:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ SSN:_____

Date of Birth: ____/____/_____

Witness Signature:_____ Date:_____

Please fax completed form to:

PAMELA A. WARREN
WC COORDINATOR
NORTHWEST GEORGIA RESA
FAX: 706-295-6069

ATTENDING PHYSICIAN'S REPORT

I hereby request medical treatment and authorize the physician(s) to release to my employer or its representative all information, opinions, and conclusions found as a result of his/her evaluation and/or treatment of my injury. I also consent to an alcohol/drug screen in accordance with my employer's substance abuse policy.

Employee Name:_____ **SSN#:**_____

Employee Signature:_____ **Date:**_____

Instructions to attending physician: Please complete this form and return to the employee. Please note that we have extensive modified duty available. Be sure to give us any specific limitations our employee may have and we will gladly accommodate. **Please note that if employee needs referral to a specialist, our office MUST be contacted prior to the referral.

Diagnosis:_____

Treatment:_____

Recheck:_____

WORK STATUS REPORT

_____Regular duty/no restrictions

_____Modified duty/as listed below (duration:_____ days).

_____No work (duration: _____ days). ***Please call our manager to discuss the availability of modified duty prior to placing the employee on a "No Work" restriction.*

Modified Duty Restrictions:

_____ No climbing

_____ No pushing

_____ No standing/walking

_____ No reaching

_____ No bending/stooping

_____ No operating heavy machinery

_____ No lifting over ____ pounds

_____ Other restrictions:_____

Physician Signature:_____ **Date:**_____