

SUA Georgia Claim Kit



GEORGIA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES GEORGIA

The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process. Included in this packet is the following:

- How to file a work related injury or illness.
- State forms as well as an explanation for completion and how to process:
 - Georgia Employer's First Report of Injury or Occupational Disease – Form WC-1 (rev. 07/2007)
 - Georgia Wage Statement – Form WC-6 (rev. 07/2007)
 - Georgia Notice to Employee of Medical Release to Return to Work with Restrictions or Limitation – Form WC-104 (rev. 07/2007)
 - Georgia Authorization and Consent to Release Information – Form WC-207 (rev. 07/2007)
 - Georgia Notice to Employee of Offer of Suitable Employment – Form WC-240 (rev. 07/2008)
 - Georgia Job Analysis – Form WC240a (rev. 07/2007)
 - Georgia Bill of Rights for Injured Worker – Form WC-Bill of Rights (rev. 07/2007) – English/Spanish
 - Official Notice – Form WC-P1 (rev. 07/2006) – English/Spanish
 - Official Notice – Form WC-P2 (rev. 07/2006) – English/Spanish
 - Official Notice – Form WC-P3 (rev. 07/2006) – English/Spanish
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Poster Requirements:
 - Employers must post the Employees' Bill of Rights in a conspicuous place or places in or about the workplace.



- Employers must post in a conspicuous place or places in or about the workplace a Regular Panel of Physicians, Conformed Panel of Physicians or a Managed Care Organization (WC/MCO) form to satisfy one of the requirements for furnishing medical care.

Thank you for choosing SUA Insurance Company



HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the Employer's First Report of Injury or Occupational Disease, Form WC-1 (rev. 07/2007) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**
- Complete the Employer's First Report of Injury or Occupational Disease, Form WC-1 (rev. 07/2007) and fax to SUA at 877-782-3292.
- Complete and mail the Employer's First Report of Injury or Occupational Disease, Form WC-1 (rev. 07/2007) to:

SUA Insurance Company
Attn: Claims Dept.
P.O. Box 06110
Chicago, IL 60606-6110

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.
- An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.



TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

SUA03 08/08



STATE FORMS GEORGIA

- [Georgia Employer's First Report of Injury or Occupational Disease – Form WC-1 \(rev. 07/2007\)](#) – The employer must complete Section A of this form immediately upon its knowledge of an injury and send the form to its insurance carrier. **FAILURE TO DO SO MAY Result IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
- [Georgia Wage Statement – Form WC-6 \(rev. 07/2007\)](#) – This form should be completed by the employer and submit to the insurance carrier.
- [Georgia Notice to Employee of Medical Release to Return to Work with Restrictions or Limitation – Form WC-104 \(rev. 07/2007\)](#) – The employer shall use this form to notify an employee that the authorized treating physician has released the employee to return to work with restrictions or limitations. This form, with attached medical report, must be sent to the employee and counsel for the employee, within 60 days of the release to return to work.
- [Georgia Authorization and Consent to Release Information – Form WC-207 \(rev. 07/2007\)](#) – This form requires the signature of the injured employee and is supplied to medical facilities for medical records related to the work injury. This information is required in order to determine eligibility of workers' compensation benefits.
- [Georgia Notice to Employee of Offer of Suitable Employment – Form WC-240 \(rev. 07/2008\)](#) – The employer shall use this form to notify an injured employee of an offer of employment with is suitable to his/her impaired condition. This form, with all attachments, must be provided to the employee at least ten days prior to the date the injured employee is expected to return to work.
- [Georgia Job Analysis – Form WC240a \(rev. 07/2007\)](#)
- [Georgia Bill of Rights for Injured Worker – Form WC-Bill of Rights \(rev. 07/2007\) – English/Spanish](#)
This is a summary of the rights and responsibility for the injured employee.
- [Official Notice – Form WC-P1 \(rev. 07/2006\) – English/Spanish](#) – The employer must post this notice in a conspicuous place readily accessible to the employee at all times.
- [Official Notice – Form WC-P2 \(rev. 07/2006\) – English/Spanish Spanish](#) – The employer must post this notice in a conspicuous place readily accessible to the employee at all times.
- [Official Notice – Form WC-P3 \(rev. 07/2006\) – English/Spanish](#) – The employer must post this notice in a conspicuous place readily accessible to the employee at all times.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male	Birthdate	Phone Number	Employee E-mail	
	<input type="checkbox"/> Female				
Address			City	State	Zip Code
EMPLOYER	Name		NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)	
	Address			Phone Number	Employer FEIN
City		State	Zip Code	Employer E-mail	
INSURER/ SELF-INSURER	Name		Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
	Name		Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)		Address		City	State Zip Code
EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease:	
	Insurer Type Code <input type="checkbox"/> I - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> G-Guarantee Fund			List Normally Scheduled Days Off	
				<input type="checkbox"/> per Hour	<input type="checkbox"/> per Day
				<input type="checkbox"/> per Week	<input type="checkbox"/> per Month
INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm		County of Injury	Date Employer had knowledge of Initial Disability	Enter First Date Employee Failed to Work a Full Day
	Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred					
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)		If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death _____
Report Prepared By (Print or Type)			Telephone Number	Date of Report	

B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____	Weekly benefit: \$ _____	Date of disability: _____
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____			
BENEFITS ARE PAYABLE FROM _____ FOR:			
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.			
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.			

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY INJURY No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filing Form)	Signature	Date
Phone and Ext.	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwc.georgia.gov>

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address			
E-mail Address		City	State	Zip Code	
EMPLOYER	Name	Address			
E-mail Address		City	State	Zip Code	
INSURER/ SELF-INSURER	Name		Address		
CLAIMS OFFICE	Name	SBWC ID# (five digit number)			
E-mail Address		Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment.

13 Weeks of Employee's Wages
 13 Weeks of a Similar Employee's Wages
 Full time weekly wage of injured employees
 Wage at date of injury per week:

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
Total										
Average Weekly Earnings										

C.	REMARKS:
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Type or Print Name	Signature	Date
E-mail Address	Phone Number	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>
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WC-104 NOTICE TO EMPLOYEE OF MEDICAL RELEASE TO RETURN TO WORK WITH RESTRICTIONS OR LIMITATIONS
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE TO EMPLOYEE OF MEDICAL RELEASE TO RETURN TO WORK
WITH RESTRICTIONS OR LIMITATIONS

Instructions: The employer shall use this form to notify an employee that the authorized treating physician has released the employee to return to work with restrictions or limitations, as required by O.C.G.A. §34-9-104(a). This form, with attached medical report, must be sent to the employee and counsel for the employee, within 60 days of the release to return to work. File the Form WC-2 and attach the Form WC-104 only when converting from TTP to TPD and attach a medical report.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION					
EMPLOYEE	County of Injury			INSURER/ SELF-INSURER	Name
	Address			CLAIMS OFFICE	Name
	City	State	Zip Code	Address	
E-mail			City	State	Zip Code
EMPLOYER	Name			SBWC ID# (five digit no.)	
	Address			Insurer/Self-Insurer File #	
	City	State	Zip Code	Phone Number	
	E-mail			E-mail	

B. NOTICE TO EMPLOYEE	
1. Your injury, which occurred on or after July 1, 1992, is not catastrophic, as defined in O.C.G.A. §34-9-200.1(g). 2. You are receiving income benefits, and are not working. 3. Your authorized treating physician, who is _____ has released you to work with restrictions or limitations on _____ 4. The limitations from the physician are as follows: _____	
A copy of the physician's report, which authorizes your release and describes your limitations, is attached.	
5. Because you have been released to return to work with restrictions, your income benefits will be reduced from \$ _____ per week to \$ _____ per week on _____, unless you return to work at an earlier date.	

<input type="checkbox"/> I certify that I have today sent a copy of this form with the attached medical report to the employee and counsel for the employee, if represented.		
Print Name	Date	Signature
Phone Number	Employer / Insurer	
E-mail		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
Social Security Number	Date of Injury	Birthdate

This document authorizes the release of only those medical records related to the injury which is the subject of this claim for workers' compensation benefits and may be required at any time during the pendency of the claim. The above-stated entity, facility or medical practitioner is authorized to release

information to _____ in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

"When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. Notwithstanding any other provisions of law to the contrary, when requested by the employer any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee."

"When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse. Said release shall designate the provider and shall state that it will expire on the date of the hearing. If the employee refuses to provide a signed release for medical information as required by this subsection, any weekly income benefits being received by the employee shall be suspended and no hearing shall be scheduled at the request of the employee until such signed release is provided."

The patient completely releases the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. This release is in compliance with Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR 164.512(1) which reads as follows: *The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault.* Anyone who receives information under this document receives the same under all protection of Federal and State law inuring to the patient.

This release shall expire in 90 days or upon written notice of revocation by the patient, whichever is later. If a hearing is pending, this release shall remain in effect until and shall expire on the date the hearing is held.

Employee / Patient Signature	Date
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IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.ga.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**NOTICE TO EMPLOYEE OF OFFER OF SUITABLE EMPLOYMENT**

Instructions: The employer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition, as required by O.C.G.A. §34-9-240. This form, with all attachments, must be provided to the employee and counsel for the employee at least ten days prior to the date the employee is expected to return to work. File the WC-2 and attach the Form WC-240 at least ten days prior to the date the employee is expected to return to work.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address			
Employee E-mail		City	State	Zip Code	
EMPLOYER	Name	Address			
Employer E-mail		City	State	Zip Code	

B. NOTICE TO EMPLOYEE

1.	This is to inform you that the following job is being made available to you pursuant to the requirements of O.C.G.A. §34-9-240 and Board Rule 240 (b):				
Title					
Essential Duties (Attach Additional Pages as needed)					
Rate of Pay			Location of Job		
Hours / Days to be Worked			Date / Time to Report for Work		
2.	A copy of the report(s) of your authorized treating physician(s), approving the job as suitable to your condition, is / are attached. If you unjustifiably refuse to attempt to perform the job offered after receiving this notification, the employer / insurer shall be authorized to suspend payment of income benefits to you effective the date you are scheduled to report to work. Should you attempt but fail to continue working for fifteen (15) scheduled work days, your income benefits shall immediately be reinstated.				
3.					
4.	If you have any questions about the job being offered to you, you may contact the employer at: _____.				

C. CERTIFICATION

<input type="checkbox"/> I hereby certify that the above-named job is available to this employee as outlined above, that the job duties have been approved by the authorized treating physician(s) who has examined the employee within 60 days of the attached approval, and that this offer is being made in good faith no later than ten days prior to the date the employee is expected to report for work. I further certify that I have this day sent a copy of this form to the employee and counsel for employer (if represented.)					
Print Name / Title Here		E-mail		Address	
Signature			Date	City	State / Zip Code

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

JOB ANALYSIS

Instructions: File this form as an attachment to a WC-240

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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EMPLOYER	Name	Contact Person
	Job Title	Position
Telephone Number	Prepared by:	Date:

SCHEDULE		
Shift(s):	Days:	
Hours / Week:	Overtime:	Rate of Pay:
JOB DESCRIPTION (What is the purpose and objective of this job?):		

WORK PACE					
Self-Paced?		Incentive Based?		Machine Paced?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Production Standards (Define Requirements):					

WEIGHT	FREQUENCY				OBJECTS	Lowest Point Lift/Lower	Highest Point Lift/Lower
	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)		Height	Height
LIFTING							
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
CARRYING						Max. Distance Carried	
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
PUSH/PULL MAX FORCE						Max. Distance Moved	
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwgc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

POSTURES / MOVEMENTS		MAX. CONSEC. MIN/HOURS	TOTAL DAILY HOURS	POSITION CHANGE OPTIONAL?	FURTHER DESCRIPTION
Sitting					
Standing (in place)					
Walking					
Use Arm/Leg Controls					
	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Turn/Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching (out)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching (up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wrist Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pinching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

LIST EQUIPMENT, MACHINES, TOOLS, VEHICLES USED

SPECIAL CONSIDERATIONS (ENVIRONMENTAL CONDITIONS, VISION, HEARING, HEIGHT)

Employer's Signature	(Title)	Date
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TO BE FILLED OUT BY THE AUTHORIZED TREATING PHYSICIAN		
<p>1. Employee can perform this job while taking medications as prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> I do release the employee to the job described</p> <p>3. <input type="checkbox"/> I do not release the employee to the job described</p> <p>4. <input type="checkbox"/> I only release the employee to the job described with the following restrictions/limitations/modifications:</p>		
Physician's Name	Physician's Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>
 WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

WC-BILL OF RIGHTS GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$500 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$500 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$334 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$334 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$500 per week. A widowed spouse with no children will be paid a maximum of \$150,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <http://www.sbcw.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

(7/2007)

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA**DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO**

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$500 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no mas de \$500 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$334 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no mas de \$334 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$500 por semana. Una esposa viuda sin niños se le pagara un máximo de \$150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbwcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

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

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.

State Board of Workers' Compensation

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
<http://www.sbwc.georgia.gov>

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

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

Name

address

phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>
Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, PREPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un médico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un cambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
o 1-800-533-0682
<http://www.sbwg.georgia.gov>

nombre /dirección /teléfono

nombre /dirección /teléfono

nombre /dirección /teléfono

nombre /dirección /teléfono

nombre /dirección /teléfono

nombre /dirección /teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)

La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

Nombre

dirección

teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: <http://www.sbwg.georgia.gov>

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

WC-P1 (7/2006)

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

OFFICIAL NOTICE

CONFORMED PANEL

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 conformed panel shall consist of at least 10 physicians, including an orthopedic surgeon, a general surgeon, and a chiropractor, 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). One change of doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682

<http://www.sbwg.georgia.gov>

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

(Additional doctors may be added on a separate sheet)

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

name

address

phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwg.georgia.gov>

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

AVISO OFICIAL

PANEL CONFORMADO

Esta compañía opera bajo las leyes de compensación de Trabajadores de Georgia.

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISARLE AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, JEFE, SUPERVISOR, O CAPATAZ.

Si un trabajador es lesionado en el trabajo, el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también le pagara una parte de los salarios perdidos. Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80). El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la junta archivados con el empleador pertenecientes a reclamos de empleados.

Un trabajador lesionado en el trabajo debe seleccionar un medico de la lista de abajo. El mínimo panel conformado debe consistir de por lo menos 10 Médicos, incluyendo un Cirujano Ortopédico, un Cirujano General, y un Quiropráctico, y no más de dos Médicos de Clínicas Industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico de minoría, cuando sea posible (Vea Regla 201 para definición de Médicos Minoritarios.) Un cambio de medico de la lista puede hacerse sin permiso. Cambios adicionales requieren permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
o 1-800-533-0682
<http://www.sbwc.georgia.gov>

nombre/dirección/teléfono

nombre/dirección/teléfono

nombre/dirección/teléfono

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nombre/dirección/teléfono

nombre/dirección/teléfono

nombre/dirección/teléfono

nombre/dirección/teléfono

nombre/dirección/teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)

La compañía de seguro que provee cobertura para esta empresa bajo la ley de Compensación de Trabajadores es:

Nombre

dirección

teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: <http://www.sbwc.georgia.gov>

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

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

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.

State Board of Workers' Compensation

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682

<http://www.sbcw.georgia.gov>

Your employer has enrolled with the certified Workers' Compensation Managed Care Organization (WC/MCO) listed below to provide all the necessary medical treatment for workers' compensation injuries. The effective date is shown below. If you had an injury prior to the effective date listed below you may continue to receive treatment from your current non-participating authorized physician until you elect to utilize the services of the WC/MCO.

Each employee will be furnished with a publication which explains in detail how to access the services of the WC/MCO and provides a complete list of the medical providers available. In addition, each employee will be given a wallet-sized card which contains information on the services of the WC/MCO including a 24-hour toll-free phone number with recorded messages of information on how to utilize these services.

NAME OF WC/MCO _____

MAILING ADDRESS _____

GEOGRAPHICAL SERVICE AREA _____

NAME OF CONTACT PERSON _____

PHONE NUMBER OF CONTACT PERSON _____

ADDRESS OF CONTACT PERSON _____

24-HOUR TOLL-FREE PHONE NUMBER _____

EFFECTIVE DATE OF WC/MCO _____

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

Name

address

phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-P3 (7/2006)

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISARLE AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, FEJE O CAPATAZ.

Si un trabajador se lesiona en el trabajo, el empleador debe pagar los gastos médicos y de rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagará una parte de los ingresos perdidos. Lesiones de trabajo y de enfermedades ocupacionales deben ser reportado por escrito cuando sea posible. El trabajador puede perder los derechos de recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. §34-9-80). El empleador ofrecerá una planilla sin costo alguno cuando sea pedida para reportar accidentes y también sin costo alguno, puede suministrar información acerca de compensación de trabajadores. El empleador también suministrará, si es pedido, al empleado, copias de planillas de la junta archivadas con el empleador pertenecientes a reclamos de los empleados.

Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-0682
404-656-3818
o 1-800-533-0682

<http://www.sbwc.georgia.gov>

Su empleador esta matriculado con la organización administrativa de cuidados de compensación de trabajadores (WC/MCO) inscrito abajo, para proveer todos los tratamientos médicos necesarios en lesiones de compensación de Trabajadores. El día efectivo aparece debajo. Si usted a tenido una lesión antes de la fecha efectiva inscrito abajo, usted puede continuar recibiendo tratamiento por su actual medico no-participante hasta que usted elija utilizar los servicios de WC/MCO.

Cada empleado se le proveerá una publicación la cual explica en detalles como adquirir los servicios de la (WC/MCO) y se le proveerá con una lista completa de los médicos proveedores disponibles. Y además, cada empleado recibirá una tarjeta tamaño billetera que contiene información de los servicios de la WC/MCO incluyendo un numero disponible las 24 horas con mensaje grabados con información de como utilizar los servicios.

NOMBRE DE WC/MCO _____

DIRECCION _____

AREA DE SERVICIO GEOGRAFICO _____

NOMBRE DE PERSONA DE CONTACTO _____

NUMERO DE TELEFONO DE PERSONA DE CONTACTO _____

DIRECCION DE PERSONA DE CONTACTO _____

NUMERO DE TELEFONO DE 24 HORAS _____

FECHA EFECTIVA DE WC/MCO _____

La compañía de seguro que provee cobertura para esta Empresa bajo la Ley de Compensación de Trabajadores es:

Nombre

Dirección

Teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: <http://www.sbwc.georgia.gov>

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

WC-P3 (7/2006)



GEORGIA FIRST REPORT OF INJURY FORMS PACKET

Georgia Employer's First Report of Injury or Occupational Disease – Form WC-1 (rev. 07/2007)

Georgia Wage Statement – Form WC-6 (rev. 07/2007)

Georgia Notice to Employee of Medical Release to Return to Work with Restrictions or Limitation – Form WC-104 (rev. 07/2007)

Georgia Authorization and Consent to Release Information – Form WC-207 (rev. 07/2007)

Georgia Notice to Employee of Offer of Suitable Employment – Form WC-240 (rev. 07/2008)

Georgia Job Analysis – Form WC240a (rev. 07/2007)

Georgia Bill of Rights for Injured Worker – Form WC-Bill of Rights (rev. 07/2007) – English/Spanish

Official Notice – Form WC-P1 (rev. 07/2006) – English/Spanish

Official Notice – Form WC-P2 (rev. 07/2006) – English/Spanish

Official Notice – Form WC-P3 (rev. 07/2006) – English/Spanish

Supervisor's Incident Report

Medical Authorization

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr		Job Title			Department					
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

SUA04 08/08



WORKERS COMPENSATION INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records And Communication Release

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

SUA05 08/08



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met	1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours 2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use foot/feet for repetitive movement as in operating foot controls <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Patient is able to: <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls																											
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.																											
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																											
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature		Date																									



Hand Coordination Activities					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine manipulation					
Gross manipulation					
Simple grasping					
Power grip					
Hand twisting					
Pushing					
Pulling					
Tools Used by Worker		Weight	No. of Hands Needed to Move		
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move	
Physical Surroundings		Does Employee Walk on Uneven Ground?			
Does Employee Work <input type="checkbox"/> Inside _____% <input type="checkbox"/> Outside _____%		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe:					
Does the Employee Come in Contact with the Following? (indicated type)		Yes	No	Type	
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics of Job that cannot be Modified by Employer for this Employee					
Comments and/or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis			Title	Date	



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the limitations my physician, Dr. _____ has placed me on while Participating in this temporary transitional work program.

Employee Signature _____

Date _____



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- You must report any accident immediately, in writing if possible, but no later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of your benefits.
- You must notify the insurance carrier/employer when you are able to return to full-time or part-time work, and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
- If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of the last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
- You have a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- You must inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting. Injuries involving seven or more days of lost time must be reported to the Board within 21 days of the employer's knowledge of disability. Failure to file timely reports with the Board and/or make timely payment of income benefits will result in late payment penalties and may result in late filing penalties and the assessment of attorney's fees.
- To avoid delay of processing the claim it is recommended, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available.
- Employers must select one of three options to provide medical care for injured employees. The choices are 1. Traditional Panel of Physicians; 2. Conformed Panel of Physicians and 3. A panel listing a Workers' Compensation Managed Care Organization certified by the Board.



- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA will report injuries on the Employer's First Report of Injury or Occupational Disease, Form WC-1, as well as all other required reports to the Board.
- SUA will ensure a timely determination of compensability by requesting from affected parties any information needed to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insureds, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA 312-258-6822.

SUA09 08/08



RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Georgia State Board of Workers' Compensation - <http://sbwc.georgia.gov> - For General Questions
800-533-0682

Georgia State Board of Workers' Compensation Benefits Information –
http://sbwc.georgia.gov/00/channel_title/0,2094,11394008_40869036,00.html

Georgia State Board of Workers' Compensation Fraud Section -
http://sbwc.georgia.gov/00/channel_title/0,2094,11394008_40869036,00.html

State of Georgia Required Workplace Notices -
http://sbwc.georgia.gov/00/article/0,2086,11394008_11400533_13292004,00.html