UWG FIRST REPORT OF INJURY

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

Section I			
Agency Name:	**University of West Georgia**	**Location Code:**	**7256**

Incident Information			
Date of Incident:		**Time:**	
Date Employer Notified:		**Time:**	

Employee Information					
Social Security Number:*					
Name:	First:	Last:		Middle Initial:	
Home Phone:		**Work Phone:**			
Cell Phone:		**Email:**			
Street Address:			**Zip Code:**		
Date of Birth:			**Male/Female:**		
Marital Status:		**Number of dependents including spouse:**			
Job Title:			**Date of Hire:**		
Full/Part Time:		**Hours per Week:**		**Wage Rate:**	
Days Normally Worked each Week (ex.W-Sun 11-7; or "varies"):					

Supervisor Information			
Name:		**Phone:**	
Title:	**Email:**		
Supervisor Signature:		**Date:**	

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

Injury Information			
Building/location of incident:			
Describe how the injury occurred:			
Type of injury: **(ex: bruised left arm, cut right leg)**			
Names/phone # of witnesses:			
Treatment Information			
Name of treatment facility:			
Facility's address/phone #:			
Treating Physician:		**Who drove the employee:**	
Lost Time Information			
Did the employee work a full day the day of the injury? (yes/no)			
Is the employee currently out of work due to the injury? (yes/no)			
What was the first FULL day the employee did not work?			
Department Information			
What time did work begin the day of the injury?			
What is the employee's department name?			
What is the department's phone number?			
SECTION II / Risk Management will fill out the following:			
CLAIM NUMBER:		**Date Filed:**	
WC Coordinator:			