Georgia Administrative Services

1775 Spectrum Drive • Lawrenceville, GA 30043
Phone: 770-963-7732 • Fax: 770-963-5754

Workers' Compensation Statement of the Injured

NAME: **MARRIED / SINGLE:**

ADDRESS: **TELEPHONE:**

SOCIAL: **DATE OF BIRTH:** **M / F:**

HEIGHT / WEIGHT: **RIGHT / LEFT HANDED:**

DEPENDENTS (NAME / AGE):

EMPLOYER: **OCCUPATION:**

DATE OF HIRE:

DATE OF ACCIDENT: **PLACE OF ACCIDENT:**

TIME OF ACCIDENT: ☐ AM ☐ PM

DESCRIBE THE ACCIDENT IN DETAIL, WHAT YOU WERE DOING, WHAT HAPPENED:

DESCRIBE YOUR INJURY:

NAME / ADDRESSES OF WITNESSES / PERSONS HAVING KNOWLEDGE:

NAME OF PHYSICIAN ARE / HAVE SEEN:

PHYSICIAN ADDRESS / PHONE:

Workers' Compensation Statement of the Injured

TO BE COMPLETED BY THE TREATING PHYSICIAN / MEDICAL PROVIDER

DATE OF FIRST VISIT:

FOLLOW UP TREATMENT:

DIAGNOSIS:

EXCUSED FROM WORK / HOW MANY DAYS:

MODIFIED WORK GIVEN / WHAT RESTRICTIONS:

HISTORY

ANY PREVIOUS ACCIDENTS OR INJURIES (work or otherwise) — PLEASE GIVE DETAILS:

DO YOU HAVE ANY SERIOUS ILLNESSES? PLEASE EXPLAIN:

PERSONAL PHYSICIAN'S NAME, ADDRESS, PHONE:

INJURED EMPLOYEE

DATE