GEORGIA DEPARTMENT OF DEFENSE STATE PERSONNEL OFFICE

Workers' Compensation INCIDENT NOTICE ONLY

Instructions: ***Complete this form for the agency's record for injuries NOT requiring outside medical care.***

For occupational injuries requiring medical attention or lost work days, call *Telephonic Reporting Center at 1-877-656-7475* as soon as possible within 24 hours of knowledge of injury (see WC Reporting Instructions).

Name of injured employee: _____

Date of Incident: _____ **Time of Incident:** _____

Date incident reported by employee: _____

Office Phone #: _____ **Job Title:** _____

Description of incident (how, where, why?): _____

_____

_____

Type of injury (cut, scrape, burn, etc.): _____

Place of occurrence (provide address if possible): _____

_____

Witness/es (name/s and telephone #): _____

_____

Was First Aid administered at time of incident? **Yes** _____ **No** _____

What type? _____

Supervisor's name: _____ **Telephone #:** _____

Person completing this report: _____ **Telephone #:** _____

Date report completed: _____

FOR INTERNAL USE - PERSONNEL RECORDS ONLY
Do NOT submit to DOAS, Risk Management
Send copy to State Personnel Office

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