Was WC Office notified (fax or email)?
Yes_____ No_____

Employee Accident Report

Richmond County School System • Worker's Compensation - Benefits Department
864 Broad Street, Suite 208 • Augusta, Georgia 30901
Ph. 706-826-1305 / 706-826-1104 • Fax: 706-826-4622• wellsan@boe.richmond.k12.ga.us

**** Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony in the third degree and are therefore subject to penalties of up to $10,000 per violation (O.C.G.A. §34-9-18 and §34-9-19).

Personal Information:

Name: _____ SSN: _____ DOB: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile: _____ E-mail: _____

Employee Information:

Hire Date: ____/____/____ Substitute: Yes or No (circle one)

School/Department: _____ Position: _____

10 Month _____
11 Month _____
12 Month _____

Hours worked per day:_____
Full Time:_____
Part Time: _____

AccidentInformation:

Date of accident: ____/____/____ Date employer aware: ____/____/____

Time of accident: _____ am/pm (circle one) Time workday began: _____ am/pm (circle one)

Place of accident: _____

If not employer's premises, provide place of accident below: _____

_____

Describe how accident occurred - what employee was doing at the time of accident. **Specific Body Parts Injured (left OR right).**

_____

_____

_____

_____