GEORGIA DEPARTMENT OF CORRECTIONS
EMPLOYEE INCIDENT NOTICE

Instructions:
Complete this form for occupational and other injuries requiring medical attention or lost workdays. For **occupational** injuries, call Teleclaim at 877-656-7475 **within 24 hours** or as soon as practical after the injury. If injured employee is seeking no medical treatment at this time, **DO NOT** call Teleclaim. Complete this form and file.

EMPLOYEE INFORMATION	
Name of injured employee:	Job Title/Work Unit/Work Telephone #:
Date of Hire:	Circle: Full-Time/ Part-Time/ Other
Social Security #:	Employee ID #:
Date of Birth:	Gender: Marital Status:
Home Address:	

INCIDENT INFORMATION		
Date of incident: Return to Work Date:	Time of incident:	Place of incident (provide address if possible):
Type of incident (Cut, burn, scrape, etc.):		Body part(s) affected (be specific, Left eye, etc.):
Description of incident (How, where, why?):		
Witness [Name(s) and telephone #]:		
Was first aid administered at the time of the incident? ☐ YES ☐ NO If YES, describe the type/by whom:		
Medical Provider Address/Phone#:		

INCIDENT REPORT INFORMATION	
Name of person completing incident report:	Telephone #:
Date/Time employee reported the incident:	Date report completed:

SUPERVISOR INFORMATION	
Name:	Telephone #:

This report does **not** replace the WC1- Employer's First Report of Injury. This is for supervisor's records for **INTERNAL USE ONLY. Do not submit to DOAS, Risk Management.**

Record Retention: Upon completion, this form shall be retained in the local medical file until replaced by the official copy of the WC-1, Employer's First Report of Injury.