

Supervisor's REPORT OF WORK RELATED INJURY

The Office Manager or a designee of the District Attorney should investigate an incident thoroughly and as quickly as possible and present the following information to DOAS no later than 24 hours following the employee's report of the incident.

Employer: Prosecuting Attorneys' Council of Georgia Circuit: _____

Address: _____

Employee Name: _____ Social Security No.: _____

Date of Birth: _____ Age: _____ Sex: _____

Employee Address: _____

Home Phone Number: _____ Office Phone No.: _____

Occupation: _____ Hire Date: _____

Full Time or Part Time?: _____ Salary: _____ (per hour/week/ or month?)

Normal Work Hours: _____ to _____ Hours Worked per Day: _____

Is the employee employed with any employer other than PACGA?: _____

If so, name of employer and phone number: _____

Date of Injury: _____ Time: _____ AM/PM Place of Occurrence: _____

Part of Body Injured (e.g., Right Hand, Lower Back, Etc.)?: _____

Type of Injury (e.g., burn, sprain, broken bone, etc.)? _____

How and why did the injury or exposure occur? Please describe possible contributing events, conditions or personal actions: _____

What was the employee doing at the time of the accident? Please be as specific as possible: _____

List all witnesses to the incident and provide statements and phone numbers if available: _____

Could this have been prevented? Yes _____ No _____ If so, how?: _____

Did the employee seek medical treatment?: Yes _____ No _____

Name and Address of Treating Physician/ Hospital: _____

Was emergency care was required?: Yes ____ No ____ Ambulance Required? Yes ____ No ____

Did the employee leave work because of the injury? Yes ____ No ____ If yes, when? _____ AM/PM

Did the employee work the next day following the injury? Yes ____ No ____

First day Employee failed to work a full day? _____ If returned to work, date: _____

If Employee has not returned to work, anticipated length of disability: _____

What are the employee's job duties? _____

Please give a brief description of any physical requirements of the job: _____

Name of Supervisor: _____

Telephone Number of Supervisor: _____

DATE YOU REPORTED INCIDENT TO DOAS (1-877-656-7475): _____

WORKERS' COMPENSATION CLAIM NO. (Provided to you by DOAS): _____

Please complete this form and be prepared to report the above information to DOAS Risk Management when calling in the Claim. After Speaking to DOAS, please email a copy of this form and all statements to Human Resources at hr@pacga.org *within 24 hours of the injury*.