

Fill in all blanks
& send to Central
Office *immediately*

Butts County Schools

Report of Employee Accident

*For Central Office
Use Only*
Emp. Date: _____
Daily Rate: _____

Full Name: _____ Address: _____ Zip Code: _____

City/State _____

Phone Number: _____ Date of Birth: _____ Social Security Number: _____

School: _____

Time Workday Begins: _____ a.m. p.m. (circle one) Hours worked per day: _____

Date of Accident: _____ Time of Accident _____ a.m. p.m. (circle one)

Description of Accident (*include which body part injured and whether left or right side*): _____

Initial Treatment: _____

Treating Physician (must be from approved Workers' Compensation Physician Panel): _____

*(Employee must present **Physicians Authorization to Treat** form to panel physician at time of treatment and if the physician writes a prescription you must get a **Preferred Medical Network Card from central office** to present to the pharmacist before you can get your prescription filled)*

Hospital (if applicable): _____

If the employee chooses not to seek medical treatment at the time of injury, he/she must complete the *Refusal of Medical Treatment* form.

If the employee chooses to seek medical treatment at a later date, he/she must obtain a *Physicians Authorization to Treat* form to present to the panel physician at the time of treatment.

I understand that in order for Workers' Compensation to cover the cost of my injury, I must choose one of the approved Workers' Compensation Physicians listed below. I also understand that if I choose not to be treated by one of the approved Workers' Compensation Physicians, I will be responsible for payment.

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Workers' Compensation Physician Panel

Dr. Shashi Madan
135 N. Oak St.
Jackson, GA 30233
770-775-7675

Aylo
1502 W. Third St., Jackson, GA
30233 678-774-0430

Georgia Bone & Joint LLC
145 Medical Blvd.
Stockbridge, GA 30281
770-389-8386 8/04/17

Family Medical Center
1657 North Expressway
Griffin GA 30223
770-228-2641

Caduceus Occupational Medicine
414 Hwy 155 South #15
McDonough GA 30253
678-902-0477

**Piedmont Orthopaedics by
OrthoAtlanta**
1240 Eagles Landing Parkway
Suite 300
Stockbridge GA. 30281
770-506-4350

Georgia Ophthalmologist
860 W. 3rd St
Jackson GA 30233
770-775-1234

11/2023

WITNESS STATEMENT

I, _____, hereby state that on _____
(your name) (date)

Please answer all that apply:

Specific location of accident? _____

Was the floor wet/dry? _____

Anything lying in the floor? _____

If the employee fell, did they hit anything as they fell? If yes what? _____

Who was present? _____

What **specific** body part was injured? _____

If injury occurred while employee was moving an object:

Approximate Weight of Object? _____

Type of object being moved? _____

I witnessed the incident as described (in Detail) below:

(Witness Signature)

(date)

Phone # _____

Address _____

REFUSAL OF MEDICAL TREATMENT

I, _____, hereby state that on _____
(your name) (date)

(Describe incident)

I _____

I reported the above incident to my supervisor on _____.
(date)

I have decided NOT to seek medical attention for this injury, even though my Workers' Compensation Coordinator/Supervisor was willing to make an appointment for me to be seen.

Refusal of medical care at the time of injury does not prohibit you from receiving medical care from a panel physician at a later date.

I returned to regular work on _____.
(date)

(Employee Signature)

(date)

(Supervisor Signature)

(date)



WORKERS COMPENSATION

PHYSICIANS AUTHORIZATION TO TREAT EMPLOYEE

Employee Name:

Date of Injury:

Type of Injury:

Job Title:

All statements will be sent directly to:

Charles Taylor
P.O. Box 436499
Louisville KY 40253-6499
678.376.0003
Toll Free - 888.245.4722
Fax - 502.489.6430

If you have any questions, please contact:

Melissa Patterson
Worker's Compensation Claims Contact
Butts County School System
181 N. Mulberry St.
Jackson GA, 30233
770.504.2300 ext. 1120
Fax – 770.504.2305

Updated: 5/27/2025