WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male ☐ Female	Birthdate	Phone Number	Employee E-mail
Mailing Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Mailing Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code ☐I – Insurer ☐S-Self-insurer ☐Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage per Week If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____

Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ **INITIAL PAYMENT** ☐ **RE-COMMENCE** ☐ **SUSPEND** ☐ **AMENDMENT:** ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE		**EMPLOYER**	Name		
Mailing Address		Mailing Address			
City	State / Zip Code	City	State	Zip Code	
Employee E-mail		Employer E-mail			
INSURER/ SELF-INSURER	Name	Insurer/Self-Insurer File #			
CLAIMS OFFICE	Name	Claims Office E-mail	State	Zip Code	
SBWC ID#	Mailing Address	City	State	Zip Code	

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of _____ *per week based on an average weekly wage of $ _____

payable from ____ / ____ / ____ for:

☐ Temporary Total Disability

☐ Temporary Partial Disability

☐ Permanent Partial Disability of _____ % to _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

Date of Disability _____

The date of the first check is, _____ , the amount is $ _____ , or date salary was paid _____ and this:

☐ Does not include a penalty

☐ Does include a _____ % penalty in the amount of $ _____ .

***File Form WC-6, Wage Statement, if weekly benefit is less than maximum.**

C. SUSPENSION OF BENEFITS

Benefits will be suspended on _____ because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced pay of $ _____ per week and temporary partial disability benefits are shown in Part B above.

☐ 4.) Employee was able to return to work on _____ without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)).

☐ 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.

☐ 6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. **A copy of the Form WC-240 is attached**.

☐ 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.

☐ 8.) The entire permanent partial disability benefit has been paid.

☐ 9.) The maximum of temporary partial disability payments has been paid.

☐ 10.) This claim is being controverted within sixty days of the due date of first payment. **File the Form WC-3 simultaneously and send a copy to the employee**.

☐ 11.) Other:

Insurer/Self-Insurer Type or Print Name	Signature	Date
Phone Number	E-mail	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this Form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation. If you need additional help, call your insurance company or self-insurer claims office.

3. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

B. NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct insurance company and their SBWC ID number.

Complete Section B, C, or D and file with the Board and send a copy of both sides of the Form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury, or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

C. NOTICE TO EMPLOYEE

This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a Form WC-14 Notice of Claim within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For information or assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free: 1-800-533-0682
Atlanta: (404) 656-3818

https://sbwc.georgia.gov

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. RIGHT TO HEARING

If your benefits have been suspended and you believe that benefits were suspended incorrectly, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
270 PEACHTREE STREET, N.W.,
ATLANTA, GEORGIA 30303-1299
404-656-3818
or: 1-800-533-0682
https://sbwc.georgia.gov

B. OUTLINE OF INCOME BENEFITS

In addition to paying your medical expenses for an injury at work, the employer will pay you for part of your lost wages if you are disabled from work for more than seven (7) calendar days because of your work-related injury.

TEMPORARY TOTAL DISABILITY (TTD)

O.C.G.A. § 34-9-261: IF YOU ARE NOT ABLE TO WORK AT ALL because of your injury, your employer/insurer must pay:

- 2/3 of your average weekly wage with a maximum of $725 per week if your date of accident was on or after July 1, 2022, and a maximum of $675 per week if your date of accident was on or after July 1, 2019. A minimum of $50.00 per week, or your actual weekly wage if less than $50.00 per week.

- If your accident occurred on or after July 1, 1992, and if your injury is not catastrophic, you are not entitled to this type of benefit for more than 400 weeks. Furthermore, your benefits may be reduced to those allowed by O.C.G.A. §34-9-262 under certain circumstances after you have been released to return to work with limitations or restrictions.

TEMPORARY PARTIAL DISABILITY (TPD)

O.C.G.A. § 34-9-262: IF YOU MUST WORK FOR LOWER WAGES because of your injury at work, your employer/insurer will pay:

- 2/3 of your wage loss (the difference between what you make after your injury and what you made before), with a maximum of $483 per week if your date of accident was on or after July 1, 2022, and a maximum of $450 per week if your date of accident was on or after July 1, 2019 for a maximum of 350 weeks from the date of accident.

PERMANENT PARTIAL DISABILITY (PPD)

O.C.G.A. § 34-9-263: IF YOU LOST A PART OR MEMBER OF YOUR BODY or lose the use of a member (such as arm, finger, eye, etc.), you will first receive benefits described above during disability, and then upon return to work or otherwise becoming ineligible for TTD or TPD benefits, you will receive payment for permanent partial disability for a certain number of weeks, based on the percentage of your loss. Multiply the permanent partial disability (%) by the maximum number of weeks listed below to determine the number of weeks you will receive PPD benefits. For example, for a 15% permanent partial disability to an arm, multiply 15% times 225 weeks. The answer of 33.75 represents the number of weeks you will receive income benefits.

Bodily Loss	Maximum Weeks
Arm	225
Leg	225
Hand	160
Foot	135
Thumb	60
Index Finger	40
Middle Finger	35
Ring Finger	30
Little Finger	25
Great Toe	30
Any toe other than great toe	20
Loss of hearing, traumatic	
One ear	75
Both ears	150
Loss of vision of one eye	150
Disability to the body as a whole	300

In all cases arising under the Workers' Compensation Law, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association.

O.C.G.A. § 34-9-220: The employer is not required to pay benefits for the first seven (7) calendar days you miss work because of your injury, unless you miss 21 consecutive days because of your injury.

O.C.G.A. § 34-9-221: If income benefits are paid late, the employer/insurer will pay you a 15% penalty on all accrued benefits. If benefits are paid late after an award has been issued, the employer/insurer will pay you a 20% penalty.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO CONTROVERT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	Mailing Address	City	State	Zip Code
Employee E-mail Address		Phone Number		
EMPLOYER	Name			Phone Number
Mailing Address				
City			State	Zip Code
Employer E-mail Address				
INSURER/ SELF-INSURER	Name		Insurer/Self-Insurer File #	
CLAIMS OFFICE	Name		Claims Office E-mail	
SBWC ID	Mailing Address			
City			State	Zip Code

B. CONTROVERT TYPES

☐ 1. This is notice, pursuant to O.C.G.A. §34-9-221, that the right to compensation in this claim is being controverted on the following specific grounds:

☐ 2. This is notice, pursuant to O.C.G.A. §34-9-200 and Board Rule 205(b), that the compensability of the following medical treatment / test is being controverted for the following specific reasons:

☐ 3. If only part of the claim is being controverted, state the specific part of the claim and the reason(s) it is being controverted:

C. CERTIFICATE OF SERVICE

☐ This is to certify that a copy of both sides of this notice has been sent to the employee / claimant(s), all counsel of record and any other person with a financial interest, as listed below:

Type or Print Name	Signature	Date
Phone Number	E-mail Address	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be given to the employee and any other person with a financial interest in the claim including, but not limited to the employer, medical care provider(s) and attorney(s).

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. NOTICE TO THE INSURER/SELF-INSURER

Board Rule 61(b)(1): An insurer who receives a Form WC-1 from an employer shall clearly stamp the date of receipt on the form, review Section A, and complete any unanswered questions. The insurer shall complete either Section B or Section C or Section D and, by the 21st day following the employer's knowledge of disability, forward the original to the Board and a copy to the employee.

Board Rule 61(b)(4): Form WC-3. Notice to Controvert Payment of Compensation. Complete Form WC-3 to controvert when a Form WC-1 has previously been filed. Furnish copies to employee and any other person with a financial interest in the claim. See subsections (d), (h), and (i) of Code § 34-9-221 and Rule 221.

O.C.G.A. § **34-9-221(d):** If the employer controverts the right of compensation, it shall file with the Board, on or before the twenty-first day after knowledge of the alleged injury or death, a notice in accordance with the form prescribed by the Board, stating that the right of compensation is controverted and stating the name of the claimant, the name of the employer, the date of the alleged injury or death, and the ground upon which the right to compensation is controverted.

Board Rule 221(d): To controvert in whole or in part the right to income benefits or other compensation use Form WC-1 or WC-3. Failure to file the Forms WC-1 or WC-3 before the 21st day after knowledge of the injury or death may subject the employer/insurer to assessment of attorney's fees. See O.C.G.A. § 34-9-108(b)(2)(3).

O.C.G.A. § **34-9-221(h):** Where compensation is being paid without an award, the right to compensation shall not be controverted except upon the grounds of change in condition or newly discovered evidence unless a notice to controvert is filed with the Board within 60 days of the due date of first payment of compensation.

Board Rule 221(h)(1): A Form WC-3 shall not be used to suspend benefits if the only issue is length of disability. In these cases, suspend benefits by filing a Form WC-2 or follow the procedure outlined in Rule 240. If liability is denied subsequent to commencement of payment, but within 60 days of due date of first payment of compensation, file Form WC-3 in addition.

O.C.G.A. § 34-9-221(i): Where compensation is being paid with or without an award and an employer or insurer elects to controvert on the grounds of a change in condition or newly discovered evidence, the employer shall, not later than 10 days prior to the due date of the first omitted payment of income benefits, file with the Board and the employee or beneficiary a notice to controvert the claim in a manner prescribed by the Board.

Board Rule 221(h)(2): If income benefits have been continued for more than 60 days after the due date of first payment of compensation, benefits may be suspended only on the grounds of a change in condition or newly discovered evidence. File Forms WC-2 or WC-2(a). When controverting a claim based on newly discovered evidence, file Form WC-3 also.

O.C.G.A. § **34-9-108(b)(2):** If any provision of Code Section § 34-9-221, without reasonable grounds, is not complied with and a claimant engages the services of an attorney to enforce rights under that Code Section and the claimant prevails, the reasonable fee of the attorney, as determined by the Board, and the costs of the proceedings may be assessed against the employer.

B. NOTICE TO THE EMPLOYEE

This claim is being controverted for the reason(s) indicated on the front of this form. If you disagree, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or: 1-800-533-0682
https://sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CASE PROGRESS REPORT (File per Board Rule 61(b)(5))

Check Only One: ☐ **Initial** ☐ **Supplemental** ☐ **Final** ☐ **Reopened**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER				

B. INDEMNITY PAYMENTS (enter actual amounts paid)

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
☐ (a) Temporary Total				
☐ (b) Temporary Partial				
☐ (c) Permanent Partial				
☐ (d) Death				
☐ (e) Stipulation/Settlement				
☐ (f) Advances				

C. TOTAL PAYMENTS TO DATE

1	Total Indemnity	
2	Physician	
3	Hospital	
4	Pharmacy	
5	Physical Therapy	
6	Chiropractic	
7	Other (Medical)	
8	Rehabilitation / Vocational (excluding all of the above)	
9	Late Payment Penalties	
10	Assessed Attorney's Fees	
11	Burial	
	Totals	

D. RECOVERY PAYMENTS

Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks

E. CERTIFICATION

☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name		Signature		Date
Address			E-mail	
City	State	Zip Code	Phone Number	
Insurer/Self Insurer Name		Claims Office Name		

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE		Mailing Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Mailing Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name			
CLAIMS OFFICE	Name	Mailing Address		
SBWC ID #	Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

❑ 13 Weeks of Employee's Wages ❑ 13 Weeks of a Similar Employee's Wages ❑ Full Time Weekly Wage of Injured Employee: $_____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
			Total							
			Average Weekly Earnings							

C. SCHEDULED DAYS OFF

REQUIRED TO COMPLETE: ❑ Mon ❑ Tue ❑ Wed ❑ Thur ❑ Fri ❑ Sat ❑ Sun ❑ No Off Days

D. REMARKS

REMARKS:

Type or Print Name	Signature	Date
E-mail Address		Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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WC-14 NOTICE OF CLAIM

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check only one: ☐ **NOTICE OF CLAIM ONLY** ☐ **REQUEST FOR HEARING / NOTICE OF CLAIM** ☐ **REQUEST FOR MEDIATION / NOTICE OF CLAIM**

Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.
If you need additional space, do not alter this form, but instead attach additional sheets. Must be typed or printed in black ink.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Mailing Address		
Employee E-mail	Phone Number		City	State	Zip Code

EMPLOYER	Name		**INSURER/ SELF- INSURER**	Name	SBWC# (five digit #)
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Employer E-mail	Phone Number		Insurer E-mail	Phone Number	

ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Mailing Address	GA Bar Number		Mailing Address	GA Bar Number	
City	State	Zip Code	City	State	Zip Code
Attorney E-mail	Phone Number		Attorney E-mail	Phone Number	

1. Part of Body Injured	2. First Date Disabled	3. If Fatal – Enter complete date of death Claimants for death benefits (list names & addresses) attach additional sheets

4. Description of Accident

B. HEARING / MEDIATION ISSUES

☐ Income Benefits ☐TTD(Dates) ☐TPD(Dates) ☐PPD(Dates)

☐ Medical Benefits List Benefits:

☐ Suspension / Termination Request Effective Date

Reason:

☐ Dependency Benefits ☐ Burial Expenses

☐ Penalties / Assessed Attorney Fees

☐§34-9-221e ☐§34-9-108b (1) ☐§34-9-108b(2) ☐Other

☐ Request for Catastrophic Designation Specify:

☐ Appeal of Rehabilitation Decision Specify:

☐ Other Hearing Issues Specify:

Additional Board Claim Numbers which will be involved (if any):

☐ _____

(Complete a separate form WC14 for each date of accident)

C. AFFIRMATION OF FILING PARTY

☐ I, [the person whose name appears above], attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

D. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

E. CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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For injuries occurring on or after July 1, 2007, any claim filed with the Board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury. (O.C.G.A. § 34-9-100)

WC-20a MEDICAL REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

MEDICAL REPORT

❑ Initial ❑ Interim ❑ Final

FAILURE TO SUBMIT THIS REPORT TO THE INSURER WILL JEOPARDIZE PAYMENT OF FEES

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

EMPLOYEE	Address	City	State	Zip Code	Phone Number	
EMPLOYER	Name		Mailing Address			
Phone Number		City		State	Zip Code	
INSURER / SELF-INSURER	Name		Mailing Address			
CLAIMS OFFICE	Name	Phone Number	City		State	Zip Code

1. Date disability began	2. Date of first treatment	3. Services authorized by ❑ Employer ❑ Dr. (name): _____ ❑ Other (specify): _____
4. Patient History		
5. Findings from Examination		6. Describe Diagnosis ICD-10 code
7. Describe Treatment		8. Prognosis

9. Date of maximum recovery	10. Doctors estimate of length of disability	11. Catastrophic Case Management Recommended
12. Date discharged as cured	13. Date patient stopped treatment without an order	14. Date patient refused treatment
15. a. Date patient able to return to work without restrictions b. Date patient able to return to work with restrictions c. List any restrictions	16. Hospital name and address if hospitalized	17. Does employee have any permanent disability? ❑ Yes ❑ No If yes, specify part of body Percentage based upon AMA guides _____ %

Date of Service	CPT/CDT Code	Medical, Surgical, and Dental Services / Drugs (itemize)	Units	Amount

Doctor's Name	FEIN / SSN	Address		
Doctor's Signature	Date	City	State	Zip Code
FILE THREE (3) COPIES WITH INSURER OR SELF-INSURER (PLEASE TYPE)				

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

WC-25 APPLICATION FOR LUMP SUM / ADVANCE PAYMENT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

APPLICATION FOR LUMP SUM / ADVANCE PAYMENT

Check only one: ☐ **APPLICATION** ☐ **OBJECTION**

When you receive this completed form, you must file any objection with the Board within 15 days of the date on the certificate of service (O.C.G.A. § 9-11-6(e)). If no response is received within the 15 day period, the Board will assume that the request is unopposed. Send to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

Board Claim No.	Claimant Last Name	Claimant First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address		
	Phone Number	City	State	Zip Code

B. APPLICATION OR OBJECTION

SELECT ONE OF THE FOLLOWING THREE OPTIONS:

☐ The employer/insurer agrees to this lump sum/advance. Complete sections C, D and F only.

☐ The claimant requests a lump sum/advance and the employer/insurer does not agree to this lump sum/advance request. Complete sections D, E, F and attach all applicable documents.

☐ This is an objection to a lump sum/advance filed by the claimant. Complete section F and attach documents in support of objection.

C. AGREEMENT

☐ The employer/insurer agrees to advance $ _____, subject to a credit, as noted above, including credit for interest at 5% per annum, unless otherwise agreed to and allowed by law. Sign below if agreed to.

Employer/Insurer	SBWC ID # (five digit no.)	Phone Number	E-mail

Signature of Employer/Insurer	Title	Date

D. AFFIDAVIT

☐ Weekly income benefits have been paid to the claimant for 26 or more weeks.

☐ The claimant would like a lump sum payment of all remaining income benefits. The claimant understands that benefits will be commuted at 5% interest per annum.

☐ The claimant would like an advance payment of a part of remaining income benefits in the amount of the $ _____. This advance will be repaid by:

- ☐ Credit to be taken when PPD is commenced (an actual or projected PPD rating must be attached) or upon settlement.
- ☐ Reducing the amount of weekly benefits by $ _____ (a current medical report must be attached).

The claimant is: ☐ Married ☐ Single ☐ Divorced ☐ Separated

The claimant has _____ dependents. Their names, ages and relationships to the claimant are:

The claimant will use this money for the following: (list the specific bills or purchases for which you need the money)

☐ The claimant hereby authorizes his/her attorney to receive a lump sum payment of $ _____ (not to exceed $500.00 or 25% of advance, whichever is less, unless specifically authorized by the Board).

☐ The claimant's attorney is waiving any claim for attorney's fees on this advance.

☐ I state under oath that all of the information is correct on both pages of this document, and that all additional information requested is attached.

Signature of Claimant

Sworn to and subscribed before me this _____ day of _____ (Month) / _____ (Year) .

Notary Public _____ My Commission Expires: _____ (Month) / _____ (Year)

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

E. STATEMENT OF MONTHLY EXPENSES AND INCOME

Attach a current medical report (completed within the last 60 days) stating your physical status, extent and duration of disability, and permanent disability rating. Also attach a copy of past due bills, a copy of estimates on any matter for which you are requesting this payment, if applicable, and other relevant documents, or your request will be denied.

EXPENSES			List Expenses per month	List all past due amounts
Housing (Rent or Mortgage Payment)			$	$
Groceries			$	$
Clothing			$	$
Child Care Expenses			$	$
Medical and Dental (Not Workers' Comp. Related)			$	$
School Expenses			$	$
Utilities (Gas, Electricity, Water, Telephone)			$	$
Loans for Car, Furniture, etc.				
Date/Loan	Name of Creditor	Balance Due	$	$
Date/Loan	Name of Creditor	Balance Due	$	$
Date/Loan	Name of Creditor	Balance Due	$	$
OTHER EXPENSES				
		TOTAL EXPENSES	$	$

INCOME		
Claimant's Workers' Compensation Benefits	$	$
Social Security Payment of Claimant	$	$
Other Income of Claimant	$	$
Income of Spouse	$	$
Income of Other Family Members Living with Claimant	$	$
TOTAL INCOME		

F. CERTIFICATE OF SERVICE

☐ I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date.

NOTE: Good faith effort to resolve issues means employer/insurer have had an opportunity to agree to advance before the request was submitted to the Board.

☐ I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.

This _____ day of _____ / _____
(Month) (Year)

Signature of Claimant or Attorney	E-mail	GA Bar Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

WC-102 REQUEST FOR DOCUMENTS TO PARTIES

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR DOCUMENTS TO PARTIES

Instructions: **NEITHER THE RESPONSE NOR REQUEST SHOULD BE FILED WITH THE BOARD.** Prior to a request for hearing being filed in a claim, the parties shall be entitled to receive from each other the documents specified in this form. These documents shall be provided without cost as requested within 30 days of the date of the certificate of service. **FAILURE OF THE PARTIES TO PROMPTLY EXCHANGE THESE DOCUMENTS MAY RESULT IN THE ASSESSMENT OF PENALTIES AND ATTORNEY'S FEES [SEE BOARD RULE 102(F)(1)]**.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address	City	State	Zip Code

EMPLOYER	Name		**INSURER / SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
			Mailing Address		
City	State	Zip Code	City	State	Zip Code
ATTORNEY FOR EMPLOYEE	Name		**ATTORNEY FOR EMPLOYER**	Name	
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

B. PRODUCTION OF DOCUMENTS

1. The employee hereby requests production of the following documents in the possession of the employer / insurer:

- ☐ Form WC-1
- ☐ Form WC-2
- ☐ Form WC-2a
- ☐ Form WC-3
- ☐ Form WC-4
- ☐ Form WC-6
- ☐ Form WC-20a
- ☐ Form WC -R1, 2 and all rehabilitation supplier reports
- ☐ Actual wage records of employee:
  - ☐ Employee, from _____ to _____
  - ☐ Similarly situated employee, from _____ to _____
- ☐ Copy of job description / analysis submitted to authorized treating physician
- ☐ Form WC-104
- ☐ Form WC-200a
- ☐ Form WC-200b
- ☐ Form WC-205
- ☐ Form WC-240 with supporting documents
- ☐ Form WC-243
- ☐ Reports prepared pursuant to Rule 200.1.(f)
- ☐ Medical records pursuant to Board Rule 200(f)(2)
- ☐ Form WC- P1, 2 or 3 utilized by the employer on the date of accident
- ☐ Employee's written or recorded statement(s)

2. The employer / insurer hereby requests production of the following document in the possession of the employee / claimant:

- ☐ Wage records applicable to calculation of TPD benefits (from _____ to _____)
- ☐ Medical records pursuant to Board Rule 200(f)(1)

C. CERTIFICATE OF SERVICE

☐ I hereby certify that I have this day sent a copy of this document to the above-named parties.

Print Name	Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE OF MEDICAL RELEASE TO RETURN TO WORK WITH RESTRICTIONS OR LIMITATIONS

Instructions: The employer shall use this form to notify an employee that the authorized treating physician has released the employee to return to work with restrictions or limitations, as required by O.C.G.A. §34-9-104(a) and Board Rule 104. This form, with attached medical report, must be filed with the Board and sent to the employee and counsel for the employee, within 60 days of the release to return to work. A Form WC-2 shall be filed with the Board when converting from TTD to TPD.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury		**INSURER/ SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
City	State	Zip Code	SBWC ID# (five digit no.)		Insurer/Self-Insurer File #
E-mail	Phone Number		Mailing Address		
EMPLOYER	Name				
Mailing Address					
City	State	Zip Code	City	State	Zip Code
E-mail	Phone Number		E-mail	Phone Number	

B. NOTICE TO EMPLOYEE

1. Your injury, which occurred on or after July 1, 1992, is not catastrophic, as defined in O.C.G.A. §34-9-200.1(g).
2. You are receiving income benefits, and are not working.
3. Your authorized treating physician, who is _____
   has released you to work with restrictions or limitations on _____
4. The limitations from the physician are as follows:

   A copy of the physician's report, which authorizes your release and describes your limitations, is attached.

5. Because you have been released to return to work with restrictions, your income benefits will be reduced from $ _____ per week to $ _____ per week on _____ , unless you return to work at an earlier date.

❑ I certify that I have today sent a copy of this form with the attached medical report to the employee and counsel for the employee, if represented.

Print Name	Date	Signature
Employer / Insurer		
E-mail	Phone Number	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT BY CONSENT

Instructions: Prior to filing this form with the Board, a Form WC-1 or WC-14 must have been previously filed with the Board. When properly executed and filed with the Board, with copies provided to the named medical provider(s), this form will be deemed approved, and made the order of the Board pursuant to O.C.G.A. §34-9-200(b).

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address		
E-mail Address		City	State	Zip Code

B. PHYSICIANS / TREATMENT

1. The currently authorized treating physician is Dr.: Name _____	Mailing Address		
	City	State	Zip Code
2. The Authorization is requested for treatment by Dr.: Name _____	Mailing Address		
	City	State	Zip Code

3. The additional treatment authorized is:

C. AGREEMENT

☐ 1. The parties agree that a change in treating physician to Dr. _____ is authorized, and the employer is to be responsible for payment of necessary and reasonable medical expenses incurred as a result of treatment rendered by this physician effective _____ / _____ / _____ .

☐ 2. The parties agree that additional medical treatment as noted above may be provided to the employee by Dr. _____ , and the employer is to be responsible for payment of necessary and reasonable medical expenses incurred as a result of treatment, effective _____ / _____ / _____ . The primary treating physician will remain Dr. _____ .

This agreement is made by:

Signature (Employee or Representative)	Signature (Employer or Representative)
Employee / Attorney Name – Print	Employer / Attorney Name – Print

Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
E-mail Address		GA Bar Number	E-mail Address		GA Bar Number

D. CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all parties, counsel and the above-named medical providers, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

Signature	E-mail	Date	Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST / OBJECTION FOR CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT

☐ REQUEST ☐ OBJECTION

Instructions: When you receive this complete form, you must file a response with the Board within 15 days of the date on the certificate of service (O.C.G.A. § 9-11-6(e)). All responses must be filed on Form WC-200b.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Name of counsel (if represented)		
Mailing Address		City	State	Zip Code

INSURER / SELF-INSURER	Name		Name of counsel (if represented)		
CLAIMS OFFICE	Name		Mailing Address		
SBWC ID# (five digit no.)	E-mail Address	Phone Number	City	State	Zip Code

B. PHYSICIANS / TREATMENT

1. The currently authorized treating physician is Dr.:	Address		
Name _____	City	State	Zip Code

2. Authorization is requested for:	Address		
☐ a Change of Physician to _____			
☐ additional treatment _____	City	State	Zip Code
Name _____			

C. ACTION REQUESTED

This action is being requested by: ☐ Employee ☐ Employer ☐ Insurer

☐ 1. A request is being made for change of primary treating physician to Dr. _____

☐ 2. A request is being made for additional medical treatment to be provided by Dr. _____
The current authorized primary treating physician shall remain authorized.

☐ 3. An objection is being filed by: ☐ Employee ☐ Employer ☐ Insurer

This request / objection is based upon the following (attach supporting documentation):

- ☐ Proximity of physician's office to employee's residence
- ☐ Accessibility of physician to employee
- ☐ Necessity for specialized care
- ☐ Language barrier
- ☐ Referral by authorized physician
- ☐ Panel of physicians
- ☐ Other: See Board Rule 200(b)(2)
- ☐ Excessive/redundant performance of medical procedures
- ☐ Noncompliance by physician with Board Rules and procedures
- ☐ Number of physicians who have treated the employee
- ☐ Prior requests for change of physician or treatment
- ☐ Employee released to normal duty work by current authorized physician
- ☐ Duration of treatment without appreciable improvement
- ☐ Current physician indicates nothing more to offer
- ☐ WC/MCO internal dispute resolution process (procedure attached)

D. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or Form WC 102B filed in compliance of Board Rule 102. (fee contract or Form WC 102B has been filed previously or is attached).

E. CERTIFICATE OF SERVICE

☐ I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation 270 Peachtree St, NW, Atlanta, GA 30303-1299 and to all parties and counsel in this claim.

Print Name Here	Phone Number	Address		
Signature	Date	City	State	Zip Code
E-mail		GA Bar number		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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WC-205 TREATMENT OR TESTING BY AUTHORIZED MEDICAL PROVIDER

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR AUTHORIZATION OF TREATMENT OR TESTING BY AUTHORIZED MEDICAL PROVIDER

Standing Order of the State Board of Workers' Compensation

Advance authorization for the medical treatment or testing of an injured employee is not required by the Georgia Workers' Compensation Act as a condition for payment of services rendered. However, an authorized medical provider may request advanced authorization for treatment or testing by completing Sections I and 2 of this form and faxing or e-mailing same to the insurer/self-insurer. The insurer/self-insurer shall respond to this request within 5 business days of receipt of this form by completing Section 3 below. If the insurer/self-insurer fails to respond to this request within the 5-day period, the treatment or testing stands pre-approved. NEITHER THE REQUEST NOR THE RESPONSE SHALL BE FILED WITH THE BOARD, UNLESS OTHERWISE REQUESTED.

Honorable Benjamin J. Vinson, Chairman
State Board of Workers' Compensation

SECTION 1. IDENTIFYING INFORMATION

PATIENT	Last Name	First Name	M.I.	Date of Injury

Employer Name	Insurer / Self-Insurer Name
Adjuster	Insurer/Self-insurer phone number
Insurer/Self-insurer E-mail	Insurer/Self-insurer Fax number

SECTION 2. REQUEST FOR TREATMENT OR TESTING AUTHORIZATION

Diagnosis	ICD-10 Code	Requested Treatment or Testing

CPT/DRG Code	Who is to provide treatment or testing?	Reason for treatment or testing

Requesting authorized medical provider		Address	
Phone Number	Fax Number	City	
E-mail		State	Zip Code

I hereby certify that this completed form was ☐ Faxed ☐ Emailed to the Insurer / Self-Insurer on this the _____ (day) day of _____ (month), _____ (year)

Signature of Authorized Requesting Medical Provider

SECTION 3. RESPONSE OF INSURER TO REQUEST FOR TREATMENT OR TESTING AUTHORIZATION

(Check appropriate item(s) and return to requesting Medical Provider by Fax or E-mail)

☐ The requested Treatment or Testing is authorized
☐ The requested Treatment or Testing is not authorized because it is:
☐ ☐ a. Not related to the on-the-job injury
☐ ☐ b. Not reasonably required to effect a cure, give relief or restore employee to suitable employment
☐ ☐ c. Not being provided by an authorized, panel or referral medical provider;
☐ ☐ d. Additional information needed (specify)
☐ ☐ e. Other (specify)

I hereby certify that this Response was ☐ Faxed ☐ Emailed to the requesting medical provider on this the _____ (day) day of _____ (month), _____ (year)

Signature of Insurer/Self-Insurer Representative

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Advance authorization for the medical treatment or testing of an employee is not required by the Workers' Compensation Act. However, in the event an authorized provider requests pre-authorization/pre-certification for treatment or tests of an employee and submits this form for such preauthorization/pre-certification to the insurer/self-insurer, the insurer/self-insurer shall respond, in writing, to this request within 5 business days from its receipt. A written request or response under this subsection shall be by facsimile transmission or e-mail. Any response to this request shall be sent directly to the requesting authorized medical provider. If the insurer/self-insurer fails to respond by completing Section 3 of this form within 5 business days, the treatment or testing stands pre-approved.

Neither the request nor the response shall be filed with the Board, unless otherwise requested.

In the event the insurer/self-insurer furnishes an initial written refusal to authorize the requested treatment or testing within the 5 business day period, then within 21 days of the initial receipt of the request for the requested treatment or testing, the insurer/self-insurer shall either:

(a) Authorize the requested treatment or testing in writing; or

(b) File with the Board a Form WC-3 controverting the treatment or testing and set forth the specific grounds for the controversion.

Advance authorization procedures for medical providers participating in a Board approved WC/MCO may be governed by the applicable contract and may vary from the provisions above. Questions regarding the applicability of the provisions above should be addressed to the plan administrator or Managed Care Division of the State Board of Workers' Compensation (404) 656-3818.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only: ❑ **PETITION** ❑ **AUTHORIZATION** ❑ **CONTROVERT**

ADVANCE AUTHORIZTION FOR THE MEDICAL TREATMENT OF TESTING OF AN INJURED EMPLOYEE IS NOT REQUIRED.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	Body Part Injured	Mailing Address	Phone Number
Employee E-mail			City / State / Zip Code	

EMPLOYER	Name	**INSURER/ SELF-INSURER**	Name / SBWC# (five digit #)
Mailing Address		**CLAIMS OFFICE**	Name
		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
Employer E-mail	Phone Number	Claims Office E-mail	Phone Number

ATTORNEY FOR EMPLOYEE/CLAIMANT	Name	**ATTORNEY FOR EMPLOYER/INSURER**	Name
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
GA Bar Number	Phone Number	GA Bar Number	Phone Number
Attorney E-mail		Attorney E-mail	

❑ B. PETITION TO SHOW CAUSE REGARDING MEDICAL TREATMENT/ TESTING RECOMMENDED BY AUTHORIZED MEDICAL PROVIDER

Authorized Medical Provider _____ has recommended the following treatment or testing:
(Name of Authorized Medical Provider)

_____
(Describe the treatment or testing requested)

Supporting documentation regarding the treatment/testing is attached.

The undersigned affirms that an authorized medical provider has recommended treatment or testing as detailed in the attached documentation, and the undersigned further affirms that the attached documentation was supplied to the employer/insurer at least **5 business days** before the date of this petition along with a request for authorization, but as of the date of this petition, no authorization has been provided. Petitioner requests the Board to issue a notice of a telephonic conference during which the employer/insurer shall be directed to show cause as the reason the medical treatment/testing has not been authorized.

Authorized Medical Provider's Address	City	State	Zip Code
Authorized Medical Provider's E-mail Address	Authorized Medical Provider's Telephone Number		

❑ C. AUTHORIZATION

The medical treatment/testing authorized by the employer/insurer is: _____
(Description of medical treatment/testing authorized)

The treatment or testing in the Petition to Show Cause filed on _____ is hereby authorized by the undersigned. Upon filing the authentication with the Board and service upon all parties, and the authorized medical provider, the scheduled Telephonic Conference is cancelled. The undersigned represents full authority to bind the employer/insurer, and certifies that all parties, and the authorized medical provider, have been served with this authorization. Authorized provided by:

Name		Signature
Date	Company/Firm Name	
E-mail Address		Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

☐ D. CONTROVERT IN LIEU OF TELEPHONIC CONFERENCE

The medical treatment/testing is controverted by the employer/insurer. Reason for controvert:

Name	Title
Signature	Date
Company/Firm Name	Phone Number
E-mail Address	

☐ E. CERTIFICATE OF SERVICE

This section must be completed.

I hereby certify that today I have served a copy of:

☐ PETITION ☐ AUTHORIZATION ☐ CONTROVERT

to all of the parties and the authorized medical provider, as appropriate, and have filed this form with the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date
Phone Number	E-mail Address	

FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only: ☐ SHOW CAUSE PETITION ☐ AGREEMENT ☐ SUSPEND BENEFITS PETITION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	Body Part Injured	Address		Phone Number
Employee E-mail			City	State	Zip Code
EMPLOYER	Name		**INSURER/ SELF- INSURER**	Name	SBWC# (five digit #)
Address			**CLAIMS OFFICE**	Name	
City	State	Zip Code	Address		Phone Number
Phone Number			City	State	Zip Code
Employer E-mail			Claims Office E-mail		
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Address			Address		
City	State	Zip Code	City	State	Zip Code
GA Bar Number	Phone Number		GA Bar Number	Phone Number	
Attorney E-mail			Attorney E-mail		

☐ B. PETITION TO SHOW CAUSE REGARDING EMPLOYEE'S FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSCIAN

An appointment was scheduled for the employee with an authorized treating physician, _____ (name of physician),

on _____ (date of appointment) _____ (time).

An authorized treating physician, _____ (name of physician), recommended testing and the appointment for testing was scheduled

on _____ (date of appointment) _____ (time).

On behalf of the employer/Insurer, the undersigned affirms that an appointment was scheduled with an authorized treating physician and/or testing was recommended by an authorized treating physician, as set forth in the attached documentation and further affirms that the employer/insurer or authorized treating physician gave notice to the employee, or the employee's attorney, on _____ .

At the time of this petition, employee has failed to attend the appointment for the follow-up evaluation or attend the appointment for the testing. Supporting documentation regarding the appointment/testing is attached.

Petitioner requests the Board to issue a notice of a telephonic conference during which the employee, or his/her representative, shall be directed to show cause as to the reason the employee failed to attend the appointment for evaluation with an authorized treating physician and/or attend the appointment for the testing recommended by an authorized treating physician.

C. AGREEMENT TO ATTEND MEDICAL APPOINTMENT

The employee and/or the employee's attorney affirm that the employee will attend the following medical appointment:

_____ (name of physician) _____ (date of appointment) _____ (time)

Upon filing of this agreement with the Board and service on all parties, the scheduled Telephonic Conference is cancelled.

FAILURE TO ATTEND THE APPOINTMENT MAY RESULT IN THE SUSPENSION OF DISABILITY BENEFITS

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

☐ **D. PETITION TO SUSPEND BENEFITS FOR FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN**

The employee has failed to attend a medical appointment as agreed or as directed by a previous order of the Board. Petitioner requests the Board to issue a notice of telephonic conference during which the employee and/or the employee's attorney shall be directed to show cause why the employee's disability benefits should not be suspended.

☐ **E. CERTIFICATE OF SERVICE**

This section must be completed.

I hereby certify that today I have served a copy of:

☐ SHOW CAUSE PETITION ☐ AGREEMENT ☐ SUSPEND BENEFITS PETITION

to all of the parties and the authorized treating physician, as appropriate, and have filed this form with the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested.

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

_____

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(l) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE OF OFFER OF SUITABLE EMPLOYMENT

Instructions: The employer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition, as required by O.C.G.A. § 34-9-240 and Board Rule 240. This form, with all attachments, must be provided to the employee and counsel for the employee at least ten days prior to the date the employee is expected to return to work. This form, along with attachments, should only be filed with the Board as an attachment to a Form WC-2.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury		Mailing Address		
Employee E-mail	Phone Number		City	State	Zip Code
EMPLOYER	Name		Mailing Address		
Employer E-mail	Phone Number		City	State	Zip Code

B. NOTICE TO EMPLOYEE

1. This is to inform you that the following job is being made available to you pursuant to the requirements of O.C.G.A. § 34-9-240 and Board Rule 240(b):

Title	
Essential Duties (Attach Additional Pages as needed)	
Rate of Pay	Location of Job
Hours / Days to be Worked	Date / Time to Report for Work

2. A copy of the report(s) of your authorized treating physician(s), approving the job as suitable to your condition, is / are attached.

3. If you unjustifiably refuse to attempt to perform the job offered after receiving this notification or if you attempt the job for less than eight cumulative hours or one scheduled work day, whichever is greater, the employer/insurer shall be authorized to suspend payment of income benefits to you effective the date you are scheduled to report to work. Should you attempt but fail to continue working for fifteen (15) scheduled work days, your income benefits shall immediately be reinstated.

4. If you have any questions about the job being offered to you, you may contact the employer at: _____ .

C. CERTIFICATE OF SERVICE

☐ I hereby certify that the above-named job is available to this employee as outlined above, that the job duties have been approved by the authorized treating physician(s) who has examined the employee within 60 days of the attached approval, and that this offer is being made in good faith no later than ten days prior to the date the employee is expected to report for work. I further certify that I have this day sent a copy of this form to the employee and counsel for employer (if represented.)

Print Name / Title Here	E-mail	Mailing Address		
Signature	Date	City	State	Zip Code

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

JOB ANALYSIS

Instructions: File this form as an attachment to a WC-240

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

EMPLOYER	Name	Contact Person
Job Title		Position
Phone Number	Prepared by:	Date:

SCHEDULE		
Shift(s):	Days:	
Hours / Week:	Overtime:	Rate of Pay:
JOB DESCRIPTION (What is the purpose and objective of this job?):		

WORK PACE		
Self-Paced? ☐ Yes ☐ No	Incentive Based? ☐ Yes ☐ No	Machine Paced? ☐ Yes ☐ No
Production Standards (Define Requirements):		

WEIGHT	FREQUENCY				OBJECTS	Lowest Point Lift/Lower	Highest Point Lift/Lower
LIFTING	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)		Height	Height
Negligible	❑	❑	❑	❑			
10 lbs. Max.	❑	❑	❑	❑			
20 lbs. Max.	❑	❑	❑	❑			
25 lbs. Max.	❑	❑	❑	❑			
50 lbs. Max.	❑	❑	❑	❑			
100 lbs. Max.	❑	❑	❑	❑			
Over 100 lbs.	❑	❑	❑	❑			
CARRYING						Max. Distance Carried	
Negligible	❑	☐	☐	☐			
10 lbs. Max.	❑	☐	☐	☐			
20 lbs. Max.	❑	☐	☐	☐			
25 lbs. Max.	❑	☐	☐	☐			
50 lbs. Max.	❑	☐	☐	☐			
100 lbs. Max.	❑	☐	☐	☐			
Over 100 lbs.	❑	☐	☐	☐			
PUSH/PULL MAX FORCE						Max. Distance Moved	
Negligible	❑	☐	☐	☐			
10 lbs. Max.	❑	☐	☐	☐			
20 lbs. Max.	❑	☐	☐	☐			
25 lbs. Max.	❑	☐	☐	☐			
50 lbs. Max.	❑	☐	☐	☐			
100 lbs. Max.	❑	☐	☐	☐			
Over 100 lbs.	❑	☐	☐	☐			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

POSTURES / MOVEMENTS		MAX. CONSEC. MIN/HOURS	TOTAL DAILY HOURS	POSITION CHANGE OPTIONAL?	FURTHER DESCRIPTION
Sitting					
Standing (in place)					
Walking					
Use Arm/Leg Controls					
	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)	
Bending	❑	❑	❑	❑	
Turn/Twisting	❑	❑	❑	❑	
Kneeling	❑	❑	❑	❑	
Squatting	❑	❑	❑	❑	
Crawling	❑	❑	❑	❑	
Climbing	❑	❑	❑	❑	
Reaching (out)	❑	❑	❑	❑	
Reaching (up)	❑	❑	❑	❑	
Wrist Turning	❑	❑	❑	❑	
Grasping	❑	❑	❑	❑	
Pinching	❑	❑	❑	❑	
Finger Manipulation	❑	❑	❑	❑	

LIST EQUIPMENT, MACHINES, TOOLS, VEHICLES USED

SPECIAL CONSIDERATIONS (ENVIRONMENTAL CONDITIONS, VISION, HEARING, HEIGHT)

Employer's Signature	(Title)	Date

TO BE FILLED OUT BY THE AUTHORIZED TREATING PHYSICIAN

1. Employee can perform this job while taking medications as prescribed ❑ Yes ❑ No
2. ☐ I do release the employee to the job described
3. ☐ I do not release the employee to the job described
4. ☐ I only release the employee to the job described with the following restrictions/limitations/modifications:

Physician's Name	Physician's Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CREDIT

Instructions: When seeking credit/reimbursement pursuant to O.C.G.A. § 34-9-243, the employer shall file this form with the State Board of Workers' Compensation, and send a copy to all counsel and unrepresented parties immediately upon seeking credit, and in any event no later than 10 days prior to a hearing.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address			
Employee E-mail		City	State	Zip Code	
EMPLOYER	Name	**INSURER/ SELF-INSURER**	Name		
Mailing Address		**CLAIMS OFFICE**	Name		
		SBWC ID# (five digit no)	E-mail		
City	State / Zip Code	Mailing Address			
Employer E-mail	Phone Number	City	State	Zip Code	

B. CREDIT REQUESTED

1. A credit is requested as allowed by O.C.G.A. § 34-9-243 for benefits paid under the "Employment Security Law" or employer funded portions of payments received by the employee pursuant to:
   - ☐ Unemployment compensation payments
   - ☐ Wage continuation plan
   - ☐ Disability plan
   - ☐ Disability insurance policy
2. The employee has been paid weekly benefits of $ _____ , from the date of _____ / _____ / _____ through _____ / _____ / _____ , for which credit is sought.
3. The ratio of the employer's contributions to the total contributions of the plan or policy is _____ %. The amount of credit per week will be calculated as follows: $ _____ (weekly disability benefit per plan or policy) X _____ (Ratio of contributions) % = $ _____ (to be credited against TTD or TPD benefits due)

Credit shall not exceed the amount of income benefits due the employee.

C. CERTIFICATE OF SERVICE

☐ I hereby certify that the above information is true and correct to the best of my knowledge and a copy of this form has been sent to the Board, to counsel, and to all unrepresented parties in this claim.

Print Name Here	Signature	Date

Phone	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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WC-262 WAGE DOCUMENTATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE DOCUMENTATION OF TEMPORARY PARTIAL DISABILITY PAYMENTS

Instructions: Complete this form when the maximum temporary partial disability benefits are not being paid and file with the Board. When paying weekly temporary partial disability income benefits, based upon an actual return to work file a Form WC-262 with the Board at 13 week intervals or when such benefits are suspended, whichever comes first. When filing the Form WC-262 with the Board, send a copy to the employee and the employee's counsel, if represented.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury		**EMPLOYER**	Name	
Mailing Address	Phone Number		Mailing Address	Phone Number	
City	State	Zip Code	City	State	Zip Code
Employee E-mail			Employer E-mail		
INSURER/ SELF-INSURER	Name		E-mail	Phone Number	
CLAIMS OFFICE	Name		Mailing Address		
SBWC ID #			City	State	Zip Code

B. TEMPORARY PARTIAL DISABILITY BENEFITS

	START DATE	END DATE	AVERAGE WEEKLY WAGE	TOTAL GROSS EARNINGS	DIFFERENCE (Weekly Wage – Gross Earnings)	PAYMENT Difference x $^2/_3$ Not to exceed maximum stated in §34-9-262
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
	TOTALS					

C. CERTIFICATION

☐ I hereby certify that to the best of my knowledge the total payments listed are correct as the available information indicates.

Print Name	E-mail	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

WC-CHANGE OF ADDRESS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR CHANGE OF ADDRESS

Instructions: This form is to be used to change address of record. Use this form to notify the Board that a party has relocated or moved. **DO NOT** file this form for a party that has been listed incorrectly in a claim.

A. EMPLOYEE/CLAIMANT CHANGE OF ADDRESS

Board Claim Number	Employee Last Name	Employee First Name	M.I.	Date of Injury

Old Phone Number			New Phone Number		
Old Mailing Address			New Mailing Address		
City	State	Zip Code	City	State	Zip Code
Old E-mail Address			New E-mail Address		

B. ALL OTHER PARTY CHANGE OF ADDRESS

☐ **EMPLOYER** | Name | FEIN

Old Phone Number			New Phone Number		
Old Mailing Address			New Mailing Address		
City	State	Zip Code	City	State	Zip Code
Old E-mail Address			New E-mail Address		

☐ **ATTORNEY** ☐ For Employee ☐ For Employer ☐ Other | Name | GA Bar number

Old Phone Number			New Phone Number		
Old Mailing Address			New Mailing Address		
City	State	Zip Code	City	State	Zip Code
Old E-mail Address			New E-mail Address		

☐ **OTHER PARTY** ☐ Insurer ☐ Claims Office ☐ Self-Insurer ☐ Party at Interest | Name

Old Phone Number			New Phone Number		
Old Mailing Address			New Mailing Address		
City	State	Zip Code	City	State	Zip Code
Old E-mail Address			New E-mail Address		

C. CERTIFICATE OF SERVICE

☐ I certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, GA 30303-1299

Print Name Here	Signature	Date

Phone Number	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE

County of Injury	Birthdate	Occupation

Mailing Address	Treating Physician

City	State	Zip Code	Physician's Specialty

Phone Number	E-mail	Diagnosis – Secondary Condition

EMPLOYER

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

INSURER/ SELF-INSURER

Name

CLAIMS OFFICE

Name	Mailing Address

City	State	Zip Code

SBWC ID# (five-digit no.)	Insurer/Self-Insurer File #

Phone Number	E-mail

ATTORNEY FOR EMPLOYEE/ CLAIMANT

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

ATTORNEY FOR EMPLOYER/ INSURER

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

OTHER PARTY

Name	Mailing Address

Phone Number	E-mail	City	State	Zip Code

CURRENT SUPPLIER

Name	Reg. No.	Mailing Address

City	State	Zip Code

Phone Number	E-mail Address

PROPOSED SUPPLIER

Name	Reg. No.	Mailing Address

City	State	Zip Code

Phone Number	E-mail Address

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

B. NOTICE OF REHABILITATION REQUEST

This section must be completed to request an initial appointment, request rehabilitation be reopened, request a change of supplier.

☐	INITIAL APPOINTMENT	Number of day from date of injury	Supplier Name	Registration No.

* If the employer / insurer request initial appointment of a supplier for an employer with a date of injury of 7/1/92 or later, the claim will automatically be accepted as catastrophic in nature, absent an objection from the employee. An Administrative Decision will be issued.

☐	REOPEN REHABILITATION	Date of Previous Closure	Supplier Name	Registration No.

☐	CHANGE OF SUPPLIER	FROM	Supplier Name	Registration No.
		TO	Supplier Name	Registration No.

C. REASON FOR REQUEST

Please complete for all requests. Use a second sheet if needed. Include copies of appropriate documents.

Do all parties agree to this request? ☐ Yes ☐ No

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

D. CERTIFICATE OF SERVICE

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Signature	Representing: ☐ Employee ☐ Employer / Insurer	Phone Number
Company / Firm Name	Mailing Address	
E-mail Address	City / State / Zip Code	

E. OBJECTIONS, TWENTY (20) DAY NOTICE

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

If a rehabilitation supplier is assigned, the employer/insurer is required to provide copies of all available medical narratives and other supporting documentation.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Occupation		
Mailing Address			Treating Physician		
City	State	Zip Code	Physician's Specialty		
Phone Number	E-mail		Diagnosis – Secondary Condition		
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
			Mailing Address		
City	State	Zip Code	City	State	Zip Code
			SBWC ID# (five-digit no.)	Insurer/Self-Insurer File #	
Phone Number	E-mail		Phone Number	E-mail	
ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/ INSURER**	Name	
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail		Phone Number	E-mail	
OTHER PARTY	Name		**PROPOSED SUPPLIER**	Name	Reg. No.
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail Address		Phone Number	Mailing Address	

B. REQUEST FOR A SPECIFIC CATASTROPHIC REHABILITATION SUPPLIER

The Board will issue an Administrative Decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an Administrative Decision naming that supplier to work with this employee.

Name of requested Catastrophic Rehabilitation Supplier	Registration No.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

C. THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's Education Level :

Employee's Work History for the last 15 years prior to injury, including physical requirements of each job (e.g. pounds lifted, hours standing / sitting / walking, etc.)

Dates/Job Title	Physical Requirements

Attach this form to a statement from this employee's authorized treating physician(s) indicating the physician(s)' opinion of the employee's work ability. This statement must be dated no more than one year prior to the certified mailing date of this form. This must be submitted even if the employee is receiving social security disability (SSDI) or supplemental security income (SSI) benefits.

D. CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Signature	Mailing Address		
Company / Firm Name			
E-mail Address	City	State	Zip Code

E. OBJECTION, TWENTY (20) DAY NOTICE

The Board will issue an Administrative Decision, whether or not an objection is received.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR SETTLEMENT MEDIATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	**EMPLOYER**	Name
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
Employee E-mail	Phone Number	Employer E-mail	Phone Number
INSURER / SELF-INSURER	Name	**PARTY AT INTEREST OR SITF**	Name
CLAIMS OFFICE	Name	Mailing Address	
SBWC ID #	Mailing Address		
City / State / Zip Code		City / State / Zip Code	
Claims E-mail	Phone Number	Party E-mail	Phone Number
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name	**ATTORNEY FOR EMPLOYER/INSURER**	Name
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
GA Bar Number		GA Bar Number	
Attorney E-mail	Phone Number	Attorney E-mail	Phone Number

B. CERTIFICATION

☐ By the filing of this Request for Settlement Mediation, all parties certify that they agree to participate in mediation for the purpose of settlement of the above referenced claim(s). The parties hereby further certify that the employer/insurer or self-insurer has obtained, or will obtain by the date of the first setting of this matter, settlement authority based upon a good faith evaluation of this claim, and that all parties are otherwise prepared to go forward. If this claim involves a request for reimbursement from the Subsequent Injury Trust Fund, the parties hereby certify that the Fund has been made aware of the settlement conference or agrees to a settlement conference and has been provided with all necessary documentation.

C. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102 (fee contract or WC-102B has been previously filed or is attached).

D. CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all of the parties named above and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Signature of Employee Representative	Date	Signature of Employer/Insurer Representative	Date
Print Name		Print Name	
E-mail	Phone Number	E-mail	Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).