

**WC- REQUEST TO CHANGE INFORMATION**

**GEORGIA STATE BOARD OF WORKERS' COMPENSATION  
REQUEST TO CHANGE INFORMATION**

Instructions: This form is to be used to correct an employee's name, SSN or Board Tracking number, county of injury or claims office that has been listed incorrectly in a claim.

Board Claim Number	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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	Change From				Change To			
<input type="checkbox"/> Employee Name								
<input type="checkbox"/> SSN or Board Tracking#								
<input type="checkbox"/> County of Injury								
<input type="checkbox"/> Claims Office	Name				Name			
	Address				Address			
	City				City			
State		Zip Code		State		Zip Code		

CERTIFICATE OF SERVICE			
<input type="checkbox"/> 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, GA 30303-1299.			
Print name	Address		
Signature	City	State	Zip Code
E-mail			GA Bar Number
Phone Number	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.sbwcc.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).