GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	Catastrophic Injury? ❑ Yes ❑ No	County of Injury	Birthdate

Treating Physician	Physician's Specialty

Diagnosis – Secondary Condition

SECTION 2 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.

SECTION 3 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

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).

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SECTION 4 CERTIFICATE OF SERVICE

❑ I certify that I have sent copies to the following parties on _____ / _____ / _____ at the current addresses below.
Month Day Year

Signature	Representing: ❑ Employee ❑ Employer / Insurer	Telephone
Company / Firm Name	Address	
E-mail Address	City / State / Zip Code	

EMPLOYEE	Last Name	First Name	M.I.	Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Address		
CLAIMS OFFICE	Name					
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
SITF	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
CURRENT SUPPLIER	Name	Telephone Number		Address		
E-mail Address		Reg. No.		City	State	Zip Code
PROPOSED SUPPLIER	Name	Telephone Number		Address		
E-mail Address		Reg. No.		City	State	Zip Code

SECTION 5 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.

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