

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REHABILITATION REGISTRATION APPLICATION Instructions and Information

CERTIFICATION REQUIREMENTS

A REHABILITATION SUPPLIER SHALL HOLD ONE OF THE ABOVE CERTIFICATIONS OR LICENSES. Please submit (1) a copy of the certificate, and (2) the notarized application.

CRC – Certified Rehabilitation Counselor

CDMS – Certified Disability Management Specialist

CWAVES – Certified Work Adjustment & Vocational Evaluation Specialist

CRRN – Certified Registered Rehabilitation Nurse Program

LPC – Licensed Professional Counselor

CCM – Certified Case Manager

COHN – Certified Occupational Health Nurse

COHN-S – Certified Occupational Health Nurse - Specialist

A *Resident Rehabilitation Supplier* (an applicant without any of the above certifications) shall **(1) submit documentation showing that they are scheduled to sit for the examination for CRC, CDMS, CWAVES, CRRN, LPC, CCM, COHN, COHN-S, (2) the notarized application and (3) academic transcript(s).** In the event a rehabilitation resident does not become certified or licensed by the appropriate licensing board within a two-year period from the date of initial application, the rehabilitation resident shall be disqualified from providing services to injured employees.

TO ELECTRONICALLY FILE, SEE INSTRUCTIONS AND REQUIREMENTS AT (WEBSITE)

OR:

TO RETURN APPLICATION VIA U.S. MAIL, SEND APPLICATION, CERTIFICATES, and/or TRANSCRIPTS AND a \$100.00 CHECK OR MONEY ORDER TO:

**YVONNE R. WATKINS
STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299
404-656-0849**

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REHABILITATION REGISTRATION APPLICATION

PERSONAL DATA								
Employee Last Name			Employee First Name			M.I.	Social Security Number	
Address				Home Phone	Cell Phone		Fax	
City		State	Zip Code	E-mail				
Employer				Employer Address				
Employer Phone				City		State	Zip Code	
ADDRESS AND PHONE NUMBER TO BE USED FOR BOARD CORRESPONDENCE? <input type="checkbox"/> HOME <input type="checkbox"/> WORK								
<i>Any change in address, phone number or e-mail MUST be reported to Yvonne R. Watkins in the Managed Care and Rehabilitation Division at the State Board of Workers' Compensation. Changes sent to other division will NOT be processed.</i>								

GENERAL DATA	
DO YOU SPEAK OR WRITE IN A FOREIGN LANGUAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, STATE LANGUAGE AND NUMBER OF YEARS	
ARE YOU ABLE TO COMMUNICATE WITH THE DEAF IN SIGN LANGUAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN CERTIFIED OR REGISTERED AS A SUPPLIER BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, STATE THE SUPPLIER NUMBER ASSIGNED	
WERE YOU REGISTERED IN ANY OTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, STATE THE NAME(S)	

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYMENT DATA	
ATTACHING A RESUME IS NOT ACCEPTABLE	
DESCRIBE YOUR WORK HISTORY BEGINNING WITH YOUR CURRENT OR MOST RECENT JOB. DESCRIBE IN DETAIL THE SPECIFIC DUTIES AND RESPONSIBILITIES FOR EACH JOB. CASE MANAGERS MUST SHOW AT LEAST ONE YEAR EXPERIENCE IN WORKERS COMPENSATION	
EMPLOYER	
ADDRESS	
PHONE	
NAME OF SUPERVISOR	
DATES (FROM AND TO)	
JOB TITLE	
DUTIES	
EMPLOYER	
ADDRESS	
PHONE	
NAME OF SUPERVISOR	
DATES (FROM AND TO)	
JOB TITLE	
DUTIES	
EMPLOYER	
ADDRESS	
PHONE	
NAME OF SUPERVISOR	
DATES (FROM AND TO)	
JOB TITLE	
DUTIES	
HAVE YOU EVER HAD ANY BUSINESS OR PROFESSIONAL LICENSE REVOKED, SUSPENDED, OR ANNULLED OR HAD ANY OTHER DISCIPLINARY ACTION TAKEN AGAINST YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN	

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE WITHIN THE STATE OF GEORGIA? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OR PLED NOLO CONTENDRE IN A CRIMINAL PROCEEDING? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, EXPLAIN
I HAVE READ, AND AM AWARE OF, O.C.G.A. 34-9-200.1 AND RULE 200.1. ALL OF THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE STATE BOARD OF WORKERS' COMPENSATION TO MAKE ANY INVESTIGATION OF THE FOREGOING INFORMATION. I UNDERSTAND THAT ANY OMISSION OR MISREPRESENTATION MAY RESULT IN REJECTION OR REVOCATION OF REGISTRATION.

PLEASE ALLOW 15 TO 20 BUSINESS DAYS FOR RECEIPT OF CARD.

SIGNATURE

DATE

NOTARY

EXPIRATION DATE

RETURN APPLICATION AND CHECK OR MONEY ORDER (IN THE AMOUNT OF \$100.00), ALONG WITH CERTIFICATION(S) TO:

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION
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