

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**REQUEST FOR REHABILITATION**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
-----------------	--------------------	---------------------	------	------------------------	----------------

SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	Catastrophic Injury? <input type="checkbox"/> Yes <input type="checkbox"/> 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, or request an extension of services beyond 26 weeks.

<input type="checkbox"/> INITIAL APPOINTMENT	Number of day from date of injury	Supplier Name	Registration No.
* If the employer / insurer requests initial appointment of a supplier for an employee 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.			
<input type="checkbox"/> REOPEN REHABILITATION	Date of Previous Closure	Supplier Name	Registration No.
<input type="checkbox"/> 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.sbcw.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**SECTION 4 CERTIFICATE OF SERVICE**

<input type="checkbox"/> I certify that I have mailed copies to the following parties on _____ / _____ / _____ at the current addresses below. <div style="text-align: center;">Month Day Year</div>			
Signature		Representing: <input type="checkbox"/> Employee <input type="checkbox"/> 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

<p>If there is an objection:</p> <ol style="list-style-type: none"> (1) The Objection must be in writing. (2) It must be received by the Georgia 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 written objections were placed in the mail to all parties and the principal rehabilitation supplier the same date as the Certificate of Service. <p>The Employer / Insurer is required to provide copies of all available medical narratives and other supporting documentation to the assigned rehabilitation supplier.</p>

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).