

**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
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**SECTION 1 IDENTIFYING INFORMATION**

<b>EMPLOYEE</b>	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).

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## SECTION 4 CERTIFICATE OF SERVICE

I certify that I have mailed copies to the following parties on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at the current addresses below.  
Month Day Year

Signature	Representing: <input type="checkbox"/> Employee <input type="checkbox"/> Employer / Insurer	Telephone
Company / Firm Name	Address	
E-mail Address	City	State Zip Code

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

The Employer / Insurer is required to provide copies of all available medical narratives and other supporting documentation to the assigned rehabilitation supplier.

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