GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHAB CONFERENCE

Submitted by: ❑ Claimant ❑ Employer / Insurer ❑ Supplier

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

A. IDENTIFYING INFORMATION

EMPLOYEE	Phone Number	County of Injury	**EMPLOYER**	Name	
Address			Address		Phone Number
City	State	Zip Code	City	State	Zip Code
Employee E-mail			Employer E-mail		
REHAB SUPPLIER	Name		**INSURER / SELF-INSURER**	Name	
Address	Phone Number		**CLAIMS OFFICE**	Name	
	Registration Number		Address		Phone Number
City	State	Zip Code	City	State	Zip Code
Supplier E-mail			Claims E-mail		SBWC ID# (five digit no)
ATTORNEY FOR EMPLOYEE / CLAIMANT	Name		**ATTORNEY FOR EMPLOYER / INSURER**	Name	
Address	Phone Number		Address		Phone Number
City	State	Zip Code	City	State	Zip Code
GA Bar number			GA Bar number		
Attorney E-mail			Attorney E-mail		

B. ISSUES:

C. CERTIFICATE OF SERVICE

❑ I certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, GA 30303-1299

Print Name Here	Telephone Number
Signature	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.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).