

WC-226b PETITION FOR APPOINTMENT OF TEMPORARY GUARDIANSHIP OF LEGALLY INCAPACITATED ADULT
GEORGIA STATE BOARD OF WORKERS' COMPENSATION

**PETITION FOR APPOINTMENT OF TEMPORARY GUARDIANSHIP
OF LEGALLY INCAPACITATED ADULT**

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

EMPLOYEE IDENTIFYING INFORMATION					
Address			County of Injury		
City	State	Zip Code	Employee E-mail		

PETITIONER IDENTIFYING INFORMATION					
Last Name		First Name		M.I.	Social Security Number
Address			Birthdate		County of Residence
City	State	Zip Code	Petitioner E-mail		

Re: _____, name of Legally Incapacitated Adult,
Petition for Appointment of Temporary Guardianship of Legally Incapacitated Adult.

1. Pursuant to the provisions of O.C.G.A. §34-9-226 _____
(name of petitioner)

hereby petitions the State Board of Workers' Compensation to appoint a temporary guardian for the above-referenced legally incapacitated adult to bring or defend an action under this Chapter, to receive and administer weekly income benefits on behalf of and for the benefit of said legally incapacitated adult for a period not to exceed 52 weeks and/or to compromise and terminate any claim and receive any sum in settlement for the benefit of and use of said legally incapacitated adult where the net settlement amount is less than \$50,000.

2. _____
(State the relationship between the petitioner and the incapacitated adult and attach supporting documentation including marriage certificates, birth certificates, or orders of custody or support, etc.)

3. _____
(State the reasons the guardianship is necessary including facts which support the claim of incapacity. This petition must be accompanied by an affidavit given by a qualified physician who has recently examined the alleged legally incapacitated adult.)

4. (List the names and addresses of the spouse and all adult children of the incapacitated adult who are living and whose addresses are known; or if none, then the names and addresses of the two next of kin who are living and whose addresses are known; or if only one next of kin, then that one; or if none, then the names and addresses of two adult friends.)

Name			Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code

5. (List the names and addresses of any appointed representatives of the incapacitated adult.)

Name			Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code

6. The Board should exercise its discretion and allow petitioner to receive and administer workers' compensation benefits for said legally incapacitated adult.

7. Petitioner will hold and use such property for the benefit of the legally incapacitated adult and shall be legally accountable to the legally incapacitated adult for the proper handling of such property.

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).

WC-226b PETITION FOR APPOINTMENT OF TEMPORARY GUARDIANSHIP OF LEGALLY INCAPACITATED ADULT
GEORGIA STATE BOARD OF WORKERS' COMPENSATION

ATTORNEY (If applicable)	Name		Telephone Number
Address			GA Bar Number
City	State	Zip Code	

VERIFICATION			
Personally appeared before me the undersigned petitioner who on this oath states that the facts set forth in the foregoing petition are true.			
Petitioner Name		Address	
Telephone Number	City	State	Zip Code
Sworn to and subscribed before me this _____ day of _____, _____.			
_____ Notary Public			

CERTIFICATE OF SERVICE	
<input type="checkbox"/> I hereby 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.	
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.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).

WC-226b PETITION FOR APPOINTMENT OF TEMPORARY GUARDIANSHIP OF LEGALLY INCAPACITATED ADULT
GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CONFIDENTIAL

EMPLOYEE / CLAIMANT	Name	Claim Number
_____, name of Legally incapacitated Adult, Petition for appointment of Temporary Guardianship of Legally Incapacitated Adult.		

CONSENT FORM				
I hereby authorize the State Board of Workers' Compensation to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I have attached a copy of a criminal history record check for each jurisdiction, other than Georgia, where I have resided at any time during the five year period immediately prior to the date of this petition.				
I have lived in the following states other than Georgia:				
State		Period		
I have never been arrested or convicted of any crime in Georgia or any other state except as follows:				
Date	Crime	Disposition	State	
Full Name		Signature of Petitioner		
Birthdate	Social Security Number	Address		
Sex	Race	City	State	Zip Code
Sworn to and subscribed before me this _____ day of _____, _____ . (day) (month) (year)				
_____ Notary Public				

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).