

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION

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

EMPLOYEE	Occupation	County of Injury	Birthdate
	Treating Physician	Physician's Specialty	
Diagnosis and Secondary Conditions			

SECTION 2 NOTICE OF REQUEST FOR CATASTROPHIC DESIGNATION AND APPOINTMENT OF A CATASTROPHIC REHABILITATION SUPPLIER

This section must be completed by an employee who is requesting catastrophic designation of his or her injury, if he/she wishes to request the appointment of a specific Board-registered catastrophic rehabilitation supplier.

The Board will issue an administrative decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an administrative decision naming that supplier to work with his employee.

Name of requested Rehabilitation Supplier	Registration No.
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SECTION 3 THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's Education Level :	
Employee's Work History for the last 15 years, including physical requirements of each job (e.g. pounds lifted, hours standing / sitting / walking, etc.)	
Dates/Job Title	Physical Requirements
Attach this form to a statement from this employee's authorized treating physician(s) indicating the physician(s)' opinion of the employee's work ability. This statement must be dated no more than one year prior to the certified mailing date of this form. This must be submitted even if the employee is receiving social security disability (SSDI) or supplemental security income (SSI) benefits.	

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).

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SECTION 4 CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

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

Signature		Address		
Company / Firm Name				
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

PROPOSED SUPPLIER	Name			Address		
E-mail Address		Reg. No.		City	State	Zip Code

SECTION 5 OBJECTION, TWENTY (20) DAY NOTICE

Absent written objections within 20 days of the date mailed, the Board will issue an administrative decision on the matter, whether or not an objection is received. If there is an objection, it must be in writing, must be copied to all case parties and to any/all involved rehabilitation suppliers.

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