GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR SETTLEMENT MEDIATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	**EMPLOYER**	Name
Mailing Address		Mailing Address	
City	State / Zip Code	City	State / Zip Code
Employee E-mail	Phone Number	Employer E-mail	Phone Number
INSURER / SELF-INSURER	Name	**PARTY AT INTEREST OR SITF**	Name
CLAIMS OFFICE	Name	Mailing Address	
SBWC ID #	Mailing Address		
City	State / Zip Code	City	State / Zip Code
Claims E-mail	Phone Number	Party E-mail	Phone Number
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name	**ATTORNEY FOR EMPLOYER/INSURER**	Name
Mailing Address		Mailing Address	
City	State / Zip Code	City	State / Zip Code
GA Bar Number		GA Bar Number	
Attorney E-mail	Phone Number	Attorney E-mail	Phone Number

B. CERTIFICATION

❑ By the filing of this Request for Settlement Mediation, all parties certify that they agree to participate in mediation for the purpose of settlement of the above referenced claim(s). The parties hereby further certify that the employer/insurer or self-insurer has obtained, or will obtain by the date of the first setting of this matter, settlement authority based upon a good faith evaluation of this claim, and that all parties are otherwise prepared to go forward. If this claim involves a request for reimbursement from the Subsequent Injury Trust Fund, the parties hereby certify that the Fund has been made aware of the settlement conference or agrees to a settlement conference and has been provided with all necessary documentation.

C. ENTRY OF APPEARANCE

❑ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102 (fee contract or WC-102B has been previously filed or is attached).

D. CERTIFICATE OF SERVICE

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

Signature of Employee Representative	Date	Signature of Employer/Insurer Representative	Date
Print Name		Print Name	
E-mail	Phone Number	E-mail	Phone Number

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).