

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR DOCUMENTS TO PARTIES

Instructions: **NEITHER THE RESPONSE NOR REQUEST SHOULD BE FILED WITH THE BOARD.** Prior to a request for hearing being filed in a claim, the parties shall be entitled to receive from each other the documents specified in this form. These documents shall be provided without cost as requested within 30 days of the date of the certificate of service. **FAILURE OF THE PARTIES TO PROMPTLY EXCHANGE THESE DOCUMENTS MAY RESULT IN THE ASSESSMENT OF PENALTIES AND ATTORNEY'S FEES [SEE BOARD RULE 102(F)(1)].**

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

EMPLOYEE	County of Injury	Mailing Address	City	State	Zip Code
EMPLOYER	Name		INSURER / SELF-INSURER	Name	
Mailing Address			CLAIMS OFFICE	Name	
City	State	Zip Code	Mailing Address		
			City	State	Zip Code
ATTORNEY FOR EMPLOYEE	Name		ATTORNEY FOR EMPLOYER	Name	
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

B. PRODUCTION OF DOCUMENTS

1. The employee hereby requests production of the following documents in the possession of the employer / insurer:

- | | |
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| <input type="checkbox"/> Form WC-1 | <input type="checkbox"/> Form WC-104 |
| <input type="checkbox"/> Form WC-2 | <input type="checkbox"/> Form WC-200a |
| <input type="checkbox"/> Form WC-2a | <input type="checkbox"/> Form WC-200b |
| <input type="checkbox"/> Form WC-3 | <input type="checkbox"/> Form WC-205 |
| <input type="checkbox"/> Form WC-4 | <input type="checkbox"/> Form WC-240 with supporting documents |
| <input type="checkbox"/> Form WC-6 | <input type="checkbox"/> Form WC-243 |
| <input type="checkbox"/> Form WC-20a | <input type="checkbox"/> Reports prepared pursuant to Rule 200.1.(f) |
| <input type="checkbox"/> Form WC -R1, 2 and all rehabilitation supplier reports | <input type="checkbox"/> Medical records pursuant to Board Rule 200 (f) (2) |
| <input type="checkbox"/> Actual wage records of employee: | <input type="checkbox"/> Form WC- P1, 2 or 3 utilized by the employer on the date of accident |
| | <input type="checkbox"/> Employee's written or recorded statement(s) |

Employee, from _____ / _____ / _____ to _____ / _____ / _____

Similarly situated employee, from _____ / _____ / _____ to _____ / _____ / _____

Copy of job description / analysis submitted to authorized treating physician

2. The employer / insurer hereby requests production of the following document in the possession of the employee / claimant:

- Wage records applicable to calculation of TPD benefits (from _____ / _____ / _____ to _____ / _____ / _____)
- Medical records pursuant to Board Rule 200 (f) (1)

C. CERTIFICATE OF SERVICE

I hereby certify that I have this day sent a copy of this document to the above-named parties.

Print Name	Signature	Date
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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).