

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF REPRESENTATION OF ANY PARTY OTHER THAN A CLAIMANT OR EMPLOYEE BY AN ATTORNEY

(This form is not to be filed by an attorney for claimant / employee)

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			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. NOTICE

This serves notice that Attorney:	Name			Phone Number	
	Firm Name			Fax Number	
	Mailing Address			E-mail Address	
	City	State	Zip Code	GA Bar Number	

is counsel in this case for the following named party / parties:

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

Signature	E-mail Address	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).