GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No.		Employee Last Name			Employee First Name					M.I.	Date of Injury	
				Α. (CLAIM IN	FORMA	TION					
	Birthdate		County of			lailing Addres						
EMPLOYEE												
Employee E-mail			Phone Numb	er	C	ity				St	tate	Zip Code
EMPLOYER Name						INSURER/ SELF- INSURER SBWC# (five digit #)						
Mailing Address	•				N	lailing Addres	is	•				
City			State	Zip Code	C	ity				St	tate	Zip Code
Employer E-mail Phor			Phone Numb	Phone Number			Insurer E-mail				Number	
ATTORNEY F		Name				TTORNE		RER	Name			
Mailing Address		I		GA Bar Num	nber M	lailing Addres	ss					GA Bar Number
City			State	Zip Code	С	City				St	tate	Zip Code
Attorney E-mail			Phone Numb	A	Attorney E-mail				Phone Number			
1. Part of Body Inju	ıred				2. First Date D	isabled			complete date of th benefits (list r		addresse	es) attach additional sheets
4. Description of A	ccident											
				В. І	HEARING	/ MEDI/	ATION	ISSU	ES			
☐ Income B	senetits _	□TTD(Da	· —	B. I	HEARING		ATION dical Ben		ES List Benefits	:		
☐ Income B	senerits	□TTD(Da □TPD(Da □PPD(Da	ntes)	В. І	HEARING	☐ Me	dical Ben	efits			Effectiv	ve Date
	Senerits [TPD(Da	ntes)	B. I		☐ Me	dical Ben	efits	List Benefits		Effectiv	ve Date
☐ Depende	senerits	TPD(Da	ates)			☐ Me	dical Ben	efits	List Benefits		Effectiv	ve Date
☐ Depende	ency Benefits	TPD(Da	ates) Fees			☐ Me	dical Ben	efits	List Benefits		Effectiv	ve Date
☐ Depende ☐ Penalties ☐ §34-9-2	ency Benefits	TPD(Da PPD(Da Attorney 34-9-108b	Fees	Burial Expen	ses	☐ Me	dical Ben	efits n / Terr	List Benefits	quest	Effectiv	ve Date Specify:
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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.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).