FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only: ☐ SHOW CAUSE PETITION ☐ AGREEMENT ☐ SUSPEND BENEFITS PETITION

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

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	Body Part Injured	Address		Phone Number
Employee E-mail			City	State	Zip Code
EMPLOYER	Name		**INSURER/ SELF- INSURER**	Name	SBWC# (five digit #)
Address			**CLAIMS OFFICE**	Name	
City	State	Zip Code	Address		Phone Number
Phone Number			City	State	Zip Code
Employer E-mail			Claims Office E-mail		
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Address			Address		
City	State	Zip Code	City	State	Zip Code
GA Bar Number	Phone Number		GA Bar Number	Phone Number	
Attorney E-mail			Attorney E-mail		

☐ B. PETITION TO SHOW CAUSE REGARDING EMPLOYEE'S FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSCIAN

An appointment was scheduled for the employee with an authorized treating physician, _____ (name of physician),

on _____ (date of appointment) _____ (time).

An authorized treating physician, _____ (name of physician), recommended testing and the appointment for testing was scheduled

on _____ (date of appointment) _____ (time).

On behalf of the employer/Insurer, the undersigned affirms that an appointment was scheduled with an authorized treating physician and/or testing was recommended by an authorized treating physician, as set forth in the attached documentation and further affirms that the employer/insurer or authorized treating physician gave notice to the employee, or the employee's attorney, on _____ .

At the time of this petition, employee has failed to attend the appointment for the follow-up evaluation or attend the appointment for the testing. Supporting documentation regarding the appointment/testing is attached.

Petitioner requests the Board to issue a notice of a telephonic conference during which the employee, or his/her representative, shall be directed to show cause as to the reason the employee failed to attend the appointment for evaluation with an authorized treating physician and/or attend the appointment for the testing recommended by an authorized treating physician.

C. AGREEMENT TO ATTEND MEDICAL APPOINTMENT

The employee and/or the employee's attorney affirm that the employee will attend the following medical appointment:

_____ (name of physician) _____ (date of appointment) _____ (time)

Upon filing of this agreement with the Board and service on all parties, the scheduled Telephonic Conference is cancelled.

FAILURE TO ATTEND THE APPOINTMENT MAY RESULT IN THE SUSPENSION OF DISABILITY 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.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).

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☐ **D. PETITION TO SUSPEND BENEFITS FOR FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN**

The employee has failed to attend a medical appointment as agreed or as directed by a previous order of the Board. Petitioner requests the Board to issue a notice of telephonic conference during which the employee and/or the employee's attorney shall be directed to show cause why the employee's disability benefits should not be suspended.

☐ **E. CERTIFICATE OF SERVICE**

This section must be completed.

I hereby certify that today I have served a copy of:

☐ SHOW CAUSE PETITION ☐ AGREEMENT ☐ SUSPEND BENEFITS PETITION

to all of the parties and the authorized treating physician, as appropriate, and have filed this form with the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail