GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION

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

A. IDENTIFYING INFORMATION

EMPLOYEE	Occupation	County of Injury	Birthdate

Treating Physician	Physician's Specialty

Diagnosis – Secondary Condition

B. NOTICE OF REHABILITATION REQUEST

This section must be completed to request an initial appointment, request rehabilitation be reopened, request a change of supplier.

☐ INITIAL APPOINTMENT	Number of day from date of injury	Supplier Name	Registration No.

* If the employer / insurer request initial appointment of a supplier for an employer with a date of injury of 7/1/92 or later, the claim will automatically be accepted as catastrophic in nature, absent an objection from the employee. An Administrative Decision will be issued.

☐ REOPEN REHABILITATION	Date of Previous Closure	Supplier Name	Registration No.

☐ CHANGE OF SUPPLIER	FROM	Supplier Name	Registration No.
	TO	Supplier Name	Registration No.

C. REASON FOR REQUEST

Please complete for all requests. Use a second sheet if needed. Include copies of appropriate documents.

Do all parties agree to this request? ☐ Yes ☐ No

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. CERTIFICATE OF SERVICE

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses below.

Signature	Representing: ☐ Employee ☐ Employer / Insurer	Phone Number
Company / Firm Name	Mailing Address	
E-mail Address	City	State / Zip Code

EMPLOYEE	Last Name	First Name	M.I.	Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYER	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Mailing Address		
CLAIMS OFFICE	Name					
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
OTHER PARTIES OR SITF	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code
CURRENT SUPPLIER	Name	Phone Number		Mailing Address		
E-mail Address		Reg. No.		City	State	Zip Code
PROPOSED SUPPLIER	Name	Phone Number		Mailing Address		
E-mail Address		Reg. No.		City	State	Zip Code

E. OBJECTIONS, TWENTY (20) DAY NOTICE

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

If a rehabilitation supplier is assigned, the employer/insurer is required to provide copies of all available medical narratives and other supporting documentation.

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