GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION

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

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Occupation		
Mailing Address			Treating Physician		
City	State	Zip Code	Physician's Specialty		
Phone Number	E-mail		Diagnosis – Secondary Condition		
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
			Mailing Address		
City	State	Zip Code	City	State	Zip Code
			SBWC ID# (five-digit no.)	Insurer/Self-Insurer File #	
Phone Number	E-mail		Phone Number	E-mail	
ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/ INSURER**	Name	
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail		Phone Number	E-mail	
OTHER PARTY	Name		**PROPOSED SUPPLIER**	Name	Reg. No.
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail Address		Phone Number	E-mail Address	

B. REQUEST FOR A SPECIFIC CATASTROPHIC REHABILITATION SUPPLIER

The Board will issue an Administrative Decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an Administrative Decision naming that supplier to work with this employee.

Name of requested Catastrophic Rehabilitation Supplier	Registration No.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://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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C. THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's Education Level :

Employee's Work History for the last 15 years prior to injury, including physical requirements of each job (e.g. pounds lifted, hours standing / sitting / walking, etc.)

Dates/Job Title	Physical Requirements

Attach this form to a statement from this employee's authorized treating physician(s) indicating the physician(s)' opinion of the employee's work ability. This statement must be dated no more than one year prior to the certified mailing date of this form. This must be submitted even if the employee is receiving social security disability (SSDI) or supplemental security income (SSI) benefits.

D. CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

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

Signature	Mailing Address		
Company / Firm Name			
E-mail Address	City	State	Zip Code

E. OBJECTION, TWENTY (20) DAY NOTICE

The Board will issue an Administrative Decision, whether or not an objection is received.

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.