

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REQUEST FOR REHAB CONFERENCE

Submitted by:  Claimant  Employer / Insurer  Supplier

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>	Phone Number	County of Injury	<b>EMPLOYER</b>	Name
Mailing Address			Mailing Address	Phone Number
City	State	Zip Code	City	State
Employee E-mail		Phone Number	Employer E-mail	
<b>REHAB SUPPLIER</b>	Name		<b>INSURER / SELF-INSURER</b>	Name
Mailing Address		Phone Number	<b>CLAIMS OFFICE</b>	Name
		Registration Number	SBWC ID #	Mailing Address
City	State	Zip Code	City	State
Supplier E-mail		Phone Number	E-mail	
<b>ATTORNEY FOR EMPLOYEE / CLAIMANT</b>	Name		<b>ATTORNEY FOR EMPLOYER / INSURER</b>	Name
Mailing Address		GA Bar number	Mailing Address	
City	State	Zip Code	City	State
Attorney E-mail		Phone Number	Attorney E-mail	

### B. ISSUES:

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### C. CERTIFICATE OF SERVICE

<input type="checkbox"/> 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		
Print Name Here	Signature	Date
Phone Number	E-mail	

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).