GEORGIA STATE BOARD OF WORKERS' COMPENSATION



EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAIL	URE TO	OSUBN	MIT THIS RE	PORT TO	INSURER	IMMEDIA	TELY MA	AY RESUL	IN P	ENALTY.	MUST BE	TYPED C	R PRI	NTED IN	N BLACK INK.
Board Claim No. 0005			100 / 20 TO 1 TO 100 TO	yee Last N +0255(IA)	ame			604 004		First Name			M.I		Date of Injury
A. IDENTIF	YING	INFO	DRMATI	ON											
EMPLOYEE		lale ₀₀₅₃ emale	Birthdate 0052			Phone No.	umber			Employe X	ee E-mail				
Mailing Address 0046+0047(IA)			•		21.			O048		•		State 004 9		Zip Coo	de 0050
EMPLOYER	Name	0018						NAICS Code			Nature of E Map to N			ription	
Mailing Address 0168+0169(IA)								Phone Numb	er					0016	er FEIN
O165				State 0170	Zip Co 0167	de		Employer E-	mail						
INSURER / SELF-INSURER	2	Name	0007					Insurer/Self-I	nsurer	FEIN			urer/ Se 15	lf-Insurer	File #
CLAIMS OFFIC	E	Name	0188			O187	Office FEIN	N #		ns Office Ph m Party Ta				ce E-mail rty Tabl	
SBWC ID# (five digit From Party Table			Mailing Ad 0010+00					O012				State 0013		Zip Co	de 0014
EMPLOYMENT			Date Hired by	Employer	Job Classifi	ed Code No	0.	Numbe		s Worked P	er Week		y or Dise	t time of ease:	□ per Hour =07 □ per Day =06 □ per Week =01
Insurer Type Code		party Table		und	List N	lormally Sci	heduled D	0204	=S=Sat =F,V= \						per Week =01 per Month =04 0063
INJURY/ILLNE	ss	Time of	f Injury 003	□ am	County of I	njury			I	oate Employ njury 0040	er had knowl	edge of		III Day	ite Employee Failed to Work
Did Employee Receiv			Injury/Illness Employer's pre Yes E		Type of Inju	iry/Illness					Body Par	t Affected			
	low Injury or Illness / Abnormal Health Condition Occurred														
Treating Physician (Name ar	nd Addres	SS)	Initial Tre	eatment Give	n: 0039	Hospita	I / Treating Fa	acility (Name and A	(ddress)	If Returne	ed to Wo	ork, Give [Date: X
Х				_	inor: By Emp inor: Clinical/			X				Returned	at what	wage	X per Week
				_	mergency Ro ospitalized >							If Fatal, E Date of D		mplete	0057
Report Prepared By ((Print or	Type)									Telephone N 0159	umber			Date of Report
□ B. INCO	ME E	BENE	FITS Fo	rm WC-6	must be f	filed if w	eekly b	enefit is l	ess tl	han max	imum				
Previously Medical O			ge Weekly \					eekly benef					Da	ate of disa	bility:
Date of first Payn	nent:			Comper	nsation paid	l: \$			or Date	salary pa	id:		P	enalty p	aid: \$
BENEFITS ARE P	PAYABL	E FROI	М			FOR:									
□ Temporary to	tal disa	bility	□ Ter	mporary par	tial disabilit	у 🗆	Perma	nent partial	disabi	lity of _	%	to		1	for weeks.
UNTIL THE FILING OF F	UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.														
□ C. NOTI	CE T	о со	NTROV	ERT PA	YMENT	OF C	OMPE	NSATIO	N						
Benefits will not be pa	aid beca	use:													
☑ D. MEDI	CAL	ONL	Y INJUF	Y (No in	demnity k	enefits	are due	and/or h	ave N	IOT beer	controv	erted.)			
Insurer / Self-Insure	er: Type	or Print N	lame of Perso	n Filing Form	1		Signatur 0188	re .							Date File Date
Phone Number From party tab	le					\dashv	E-mail Fron	n Party Tab	le						

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).

WC-1 REVISION 7/2021

1

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Board Claim No.		ee Last Name	MINIEDIATELT		loyee Firs			TTPEDO	M.I.	ED IN	Date of Injury
0005		0255(IA)		004		truine			0045		0031
A. IDENTIFYING IN	FORMATIO	N									
EMPLOYEE	0053		Phone Number 0051			Employe X	e E-mail				
Mailing Address 0046+0047(IA)	•	,		City 0048				State 0049		ip Code	0050
EMPLOYER Name	018			NAICS Code	•			Business (Tr			lfg.,etc.)
Mailing Address 0168+0169(IA)				Phone Numb	er					nplover 0016	FEIN
O165		State Zip Cod 0170 0167	le	Employer E-	mail				~		
INSURER / Nat SELF-INSURER	me 0007			Insurer/Self-I		***		001	5.00		ile #
CLAIMS OFFICE Name	me 0188		Claims Office F 0187	FEIN#		office Pho Party Ta			ms Office I om Party		
SBWC ID# (five digit no.) From Party Table	Mailing Addre 0010+0011			O012				State 0013	Z	ip Code	0014
EMPLOYMENT/WAGE	Date Hired by Er	mployer Job Classifie 0059	ed Code No.	Numbe	r of Days W	orked Pe	er Week		rate at tin or Diseas		□ per Hour =07 □ per Day =06 □ per Week =01
Insurer Type Code From party		28	ormally Schedule	0204	=S=Sat, Su =F,V= Varie						per Week =01 per Month =04 0063
INJURY/ILLNESS & MEDICAL		County of In	jury		Date Injury	У	er had knowl	edge of	Enter F a Full D 0056		e Employee Failed to Work
Pay on Date of Injury? 0066 Yes No	Pay on Date of Injury? 0066 on Employer's premises' LORX 0035										
Treating Physician (Name and Ad		Initial Treatment Given	i: Hos	pital / Treating Fa	cility (Nan	ne and A	ddress)				
х	*	☐ None o ☐ Minor: By Emplo	0039 Hos	X				If Returned			
		☐ Minor: Clinical/H ☐ Emergency Roc	om 3				-	If Fatal, Er	nter Compl	7.000	0057 per Week
Report Prepared By (Print or Type)	☐ Hospitalized > 2	24nrs •			Τ.	Telephone N	Date of De umber	eatn		Date of Report
0160	,						0159				0041
☐ B. INCOME BEN	NEFITS Form	n WC-6 must be fi	iled if weekly	y benefit is l	ess thar	n maxi	mum				
Previously Medical Only Yes No Av	erage Weekly Wa	age: \$		Weekly benef	t: \$				Date	of disab	ility:
Date of first Payment:		Compensation paid:	: \$		or Date sa	lary pai	d:		Pen	alty pa	iid: \$
BENEFITS ARE PAYABLE F	ROM		FOR:								
☐ Temporary total disability	/ \square Temp	orary partial disability	/ □ Per	manent partial	disability	of _	%	to		fo	or weeks.
UNTIL THE FILING OF FORM WC-2	UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.										
C. NOTICE TO	CONTROVE	RT PAYMENT	OF COM	PENSATIO	N						
Benefits will not be paid because: 0294+0197											
□ D. MEDICAL ON	NLY INJURY	(No indemnity b	enefits are d	lue and/or h	ave NO	Γ been	controv	erted.)			
Insurer / Self-Insurer: Type or Pr	int Name of Person	Filing Form	Sign 014	ature							Date File Date
Phone Number 0137			E-ma	ail							



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

	URE T	O SUBM				IMMEDIA	ATELY M.					E TYPED (R PRI	NTED II	N BLACK INK.
Board Claim No. 0005			Employee Last Name Employee First Name M.I. Date of Injury 0043+0255(IA) 0044 0045 0031						2000000						
A. IDENTIF	YINC	INFO	ORMATI	ON											
EMPLOYEE		Male ₀₀₅₃	Birthdate			Phone N	Number			Employe	ee E-mail				
Mailing Address		emale	0052			0051	Т	City		X		State	9	Zip Co	de
0046+0047(IA)								0048				004			0050
EMPLOYER	Name	0018						NAICS Cod				f Business (* NAICS typ		ription	1.5.0
Mailing Address 0168+0169(IA)								Phone Numb	oer					Employe 0016	er FEIN
O165				State 0170	Zip Co 0167	de		Employer E-	mail						
INSURER / SELF-INSURE	R	Name	0007					Insurer/Self- 0006				00	115	f-Insurer	
CLAIMS OFFIC	E	Name	0188			O187	Office FEI	N #	100000000000000000000000000000000000000	s Office Ph n Party T				ce E-mail rty Tab l	
SBWC ID# (five digit From Party Table	100000000000000000000000000000000000000		Mailing Ad 0010+00			•		City 0012				State 0013		Zip Co	de 0014
EMPLOYMENT	574W07720 = 4V0	20000	Date Hired by		Job Classif	ied Code N	No.	200000000000000000000000000000000000000		s Worked F	er Week	Wag	e rate at y or Dise		□ per Hour =07 □ per Day =06
	IVVAC	,,	0061		0059			0064	1			000	52		□ per Week =01
Insurer Type Code		n party Tabl -insurer		und	List N	Normally Se	cheduled D	020	I=S=Sat, I=F,V= V						per Month =04 0063
INJURY/ILLNE & MEDICAL	ss	Time of	Injury 003	☐ am	County of I	njury			In	ate Employ jury <mark>0040</mark>	er had kno	wledge of		II Day	ate Employee Failed to Work
Did Employee Recei			Injury/Illness		Type of Inju	ury/Illness					Body F	Part Affected			
Pay on Date of Injury Yes	No			☐ No	0035						0036				
How Injury or Illness	/ Abnor	mal Health	n Condition O	ccurred											
Treating Physician (Name a	nd Addres	SS)		eatment Give	on: 0039	Hospita	al / Treating F	acility (N	Name and A	(ddress)	If Return	ed to Wo	rk, Give I	Date: X
X					linor: By Emp			X				Returned	at what	wage	X per Week
				□ E	mergency Ro ospitalized >	oom 3						If Fatal, E		nplete	0057
Report Prepared By	(Print or	Type)					-				Telephone	Number			Date of Report
0160											0159				0041
☐ B. INCO		BENE	FITS Fo	rm WC-6	must be t	filed if v	veekly b	enefit is l	ess th	an max	imum				
Previously Medical C	Only No	Averag	ge Weekly V	Vage: \$			W	eekly benef	it: \$ _				Da	te of disa	ability:
Date of first Payn	nent:			Compe	nsation paid	d: \$			or Date	salary pa	id:		_ P	enalty p	paid: \$
BENEFITS ARE F	PAYAB	LE FROI	М			FOR:									
☐ Temporary to	tal dis	ability	□ Ter	nporary pa	rtial disabilit	ty 🗆	Perma	anent partial	disabil	ity of _		% to			for weeks.
UNTILTHE FILING OF F	UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.														
✓ C. NOTI	CE T	осо	NTROV	ERT PA	YMENT	OF C	ОМРЕ	NSATIO	ON						
Benefits will not be p	aid bec	ause:													
□ D. MEDI	CAL	ONL	Y INJUR	Y (No in	demnity l	benefits	are du	e and/or h	ave N	OT beer	n contro	verted.)			
Insurer / Self-Insure				-			Signatu 0140								Date File Date
Phone Number						_	E-mail								
0137							0138								



EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Board Claim No.	O OODMIT	_	e Last Na		WINIEDIA I EL	- I MAI		oyee Fi	irst Name			M.I		Date of Injury	
A. IDENTIFYING	INFOR	RMATIO	N											•	
I EMPLOYEE I	Male ₀₀₅₃ E Female	Birthdate 0052			Phone Numb	er			Employe X	ee E-mail					
Mailing Address 0046+0047(IA)						City	0048				State 0049		Zip Coo	0050	
EMPLOYER Name	0018					100000	ICS Code 025				f Business (T NAICS type			Mfg.,etc.)	
Mailing Address 0168+0169(IA)						0.000	one Numbe 0 <mark>159</mark>	er					Employe 0016	er FEIN	
O165			State 1170	Zip Cod 0167	e	Em	ployer E-m	nail							
INSURER / SELF-INSURER	Name 0	007				Insi	urer/Self-In	surer Fl	EIN		Inst 00		f-Insurer	File #	
CLAIMS OFFICE	Name 01	188			Claims Office 0187	e FEIN#			Office Ph				ce E-mail rty Tabl		
SBWC ID# (five digit no.) From Party Table		Mailing Addres 0010+0011(City	0012				State 0013		Zip Co	de 0014	
EMPLOYMENT/WAC		e Hired by Em <mark>061</mark>	nployer	Job Classifie			0064	of Days	Worked P	er Week		or Dise	time of ease:		
Insurer Type Code From □I – Insurer □S-Self-	n party Table -insurer 🔲	Group Fund	d	List No	ormally Sched	uled Days	0204-	S=Sat, S F,V= Va						per Month =04 0063	
INJURY/ILLNESS & MEDICAL	Time of Inj	oury 0032] am	County of Inj	jury			Inj	ite Employ ury 1040	er had kno	wledge of		II Day	ate Employee Failed to Work	
Did Employee Receive Full Pay on Date of Injury? 0066 Yes No	on Emp	ry/Illness Occ bloyer's premis Yes E	ses'Lorx No	Type of Injur	y/Illness			•		Body F 0036	art Affected				
How Injury or Illness / Abnor	mai Health C	ondition Occu	irred												
Treating Physician (Name a	and Address)		□ No	atment Given ne 0	0039		reating Fa	cility (N	ame and A	Address)	If Returne	d to Wo	rk, Give [Date: X	
X			☐ Mir	nor: By Emplo nor: Clinical/F	lospital 2	X					Returned	at what	wage	X per Week	
			200000	nergency Roo spitalized > 2	2000						If Fatal, E		nplete	0057	
Report Prepared By (Print or 0160	Type)									Telephone 0159	Number			Date of Report 0041	
✓ B. INCOME I	BENEFI	TS Form	WC-6 r	nust be fi	led if weel	kly ben	efit is le	ss th	an max	imum					
Previously Medical Only Yes No	Average	Weekly Wag	ge: \$ _	0286		Week	ly benefit	: \$ <mark>0</mark>	134				te of disa	ability:	
Date of first Payment:			Compen	sation paid:	\$		0	r Date	salary pa	id: 00	88	_ P	enalty p	paid: \$	
BENEFITS ARE PAYAB	LE FROM	0088	8		FOR:										
Temporary total disa	ability	□ Tempo	orary part	ial disability	P	ermaner	nt partial	disabili	ty of		% to		1	for weeks.	
UNTIL THE FILING OF FORM	UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.														
□ C. NOTICE T	O CON	TROVE	RT PA	YMENT	OF COM	/IPEN	SATIO	N							
Benefits will not be paid beca	ause:														
☐ D. MEDICAL	ONLY	INJURY	(No inc	lemnity b	enefits are	due ar	nd/or ha	ve N	OT beer	n contro	verted.)				
Insurer / Self-Insurer: Type 0140	or Print Nam	ne of Person F	filing Form		100	ignature 1140								Date File Date	
Phone Number 0137						-mail 1138									



EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAIL Board Claim No. 0005	URE T	O SUBM	Emplo	PORT TO yee Last N +0255(IA)		MMEDIA	TELY MA		loyee F	irst Name		E TYPED	M.		Date of Injury
A. IDENTIF	YING	INFO	RMATI	ON											
EMPLOYEE	□ N	lale ₀₀₅₃ emale	Birthdate 0052	<u> </u>		Phone N 0051	lumber			Employe	ee E-mail				
Mailing Address 0046+0047(IA)								City 0048	1			Stat 004		Zip Co	0050
EMPLOYER	Name	0018						NAICS Code	Э			f Business (Mfg.,etc.)
Mailing Address 0168+0169(IA)								Phone Numb	er					Employ 0016	er FEIN
O165				State 0170	Zip Co. 0167	de		Employer E-	mail						
INSURER / SELF-INSURE	R	Name	0007					Insurer/Self-	nsurer F	EIN			surer/ Se 015	elf-Insure	File #
CLAIMS OFFIC	CE	Name	0188			Claims 0187	Office FEIN	N #		s Office Ph n Party Ta				ice E-ma arty Tab	
SBWC ID# (five digit From Party Tabl			Mailing Ad- 0010+00			*		O012				State 001	3	Zip Co	0014
EMPLOYMENT	Γ/WAG		Date Hired by	Employer	Job Classifi 0059	ed Code N	lo.	Numbe		s Worked P	er Week		ry or Dis	it time of ease:	□ per Hour =07 □ per Day =06 □ per Week =01
Insurer Type Code		party Table insurer		und	List N	Iormally So	cheduled D	0204	=S=Sat, =F,V= V						per Week =01 per Month =04 0063
INJURY/ILLNE & MEDICAL	ss	Time of	Injury 003	am pm	County of Ir	njury			In	ate Employ jury <mark>0040</mark>	er had kno	wledge of	a Fu	er First D ull Day 1 <mark>56</mark>	ate Employee Failed to Work
Did Employee Recei			njury/Illness (mployer's pre Yes E	Occur 0249	Type of Inju	ry/Illness					Body F	Part Affected			
How Injury or Illness		nal Health		_							<u> </u>				
Treating Physician ((Name a	nd Addres	ss)		eatment Giver	0039	Hospita	I / Treating F	acility (N	Name and A	Address)	If Return	ed to Wo	ork, Give	Date: X
X					linor: By Emp linor: Clinical/			X				Returned	d at what	t wage	X per Week
					mergency Ro ospitalized >							If Fatal, I Date of I		mplete	0057
Report Prepared By 0160	(Print or	Type)									Telephone	Number			Date of Report
✓ B. INCO	ME	BENE	FITS Fo	rm WC-6	must be f	iled if w	veekly b	enefit is l	ess th	an max	imum				
Previously Medical C	Only No	Averag	ge Weekly V	Vage: \$	0286		We	eekly benef	it: \$ _	0134				ate of dis	
Date of first Payr	ment:	0192		Compe	nsation paid	: \$ 00	86		or Date	salary pa	id:		F	Penalty p	oaid: \$
BENEFITS ARE F	PAYAB	LE FROI	M	88		FOR:				00	104	Only fo	are to a		
☐ Temporary to 050 UNTIL THE FILING OF F			070 WHEN	THE EMPL		030 UALLY R) ETURNE		K WIT	HOUT RE	STRICTI	70 to	. OTHE	R SUSF	for 0090 weeks. PENSIONS REQUIRE
□ C. NOTI	CE T	о со	NTROV	ERT PA	YMENT	OF C	ОМРЕ	NSATIO	N						
Benefits will not be p	oaid beca	iuse:													
□ D. MED	ICAL	ONL	Y INJUR	Y (No in	demnity b	enefits	are due	and/or h	ave N	OT beer	n contro	verted.)			
Insurer / Self-Insur 0140	er: Type	or Print N	ame of Perso	n Filing Forn	1		Signatur 0140	re .							Date File Date
Phone Number 0137							E-mail 0138							1	

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Board Claim No.	E TO SUB	Emple	oyee Last N		MMEDIA	ATELY MA	Emp	loyee	First Nam		BEITPE	D OK	M.I.	Date	of Injury
0005			+0255(IA)				004	4					0045	003	1
A. IDENTIFYI	Male 0053		ON		Phone N	lumbor			T = .						
EMPLOYEE	20000	0052			0051				X	yee E-mail					
Mailing Address 0046+0047(IA)							0048				0	0049		0050 0050	
EMPLOYER No	ome 0018	3				1	NAICS Code	Э					le, Transpo <mark>lescriptio</mark>	rt, Mfg.,etc.) n	1
Mailing Address 0168+0169(IA)						P	hone Numb	er					Empl 001	over FEIN	
O165			State 0170	Zip Coc 0167	de	E	mployer E-	mail							
INSURER / SELF-INSURER	Name	0007			-24	92	nsurer/Self-l					0015		2011	
CLAIMS OFFICE	Name	0188			Claims 0187	Office FEIN	#		ms Office P m Party 1				office E-m Party Ta		
SBWC ID# (five digit no. From Party Table)	Mailing Ac 0010+00				C	0012					ate 013	Zip	Code 00	14
EMPLOYMENT/W	AGE	Date Hired by	Employer	Job Classifie	ed Code N	No.	Numbe		ys Worked	Per Week			ate at time o Disease:	of 🗆	per Hour =07 per Day =06
Insurer Type Code				1 100 00 000	Iormally S	cheduled Day						0062			per Week =01 per Month =04
□I – Insurer □S-S	From party Tal Self-insurer		und		, , ,		0204	=S=Sa =F,V= \	Varies					_	0063
INJURY/ILLNESS & MEDICAL	Time	of Injury 003	am pm	County of In	njury				Date Emplo Injury 0040	yer had kno	owledge o		Enter First a Full Day 0056	Date Emplo	yee Failed to Work
Did Employee Receive F Pay on Date of Injury?		I Injury/Illness Employer's pr Yes E	Occur 0249	Type of Inju	ry/Illness					Body 003	Part Affec	ted			
How Injury or Illness / Ab	normal Heal	th Condition C	ccurred												
Treating Physician (Nan	ne and Addre	ess)		reatment Giver	0039	Hospital /	Treating F	acility	(Name and	Address)	If Ret	urned to	o Work, Giv	e Date:	Х
X				Minor: By Empl Minor: Clinical/I	-	X	(Retur	ned at v	what wage		X per Week
			_	Emergency Roo Hospitalized > 2								al, Ente	r Complete h	00	057
Report Prepared By (Prin	nt or Type)					•				Telephone 0159	e Number			Date of 0041	Report
☐ B. INCOM	E BENE	FITS Fo	rm WC-6	must be f	iled if v	weekly be	nefit is I	ess t	han max	cimum					
Previously Medical Only Yes N		age Weekly \					ekly benef						Date of d	lisability:	
Date of first Paymen	t:		Compe	ensation paid	: \$			or Date	e salary p	aid:			Penalty	y paid: \$	
BENEFITS ARE PAY	ABLE FRO	OM			FOR:										
☐ Temporary total	disability	□ Ter	mporary pa	rtial disability	у 🗆	Perman	ent partial	disab	ility of		% to			for	weeks.
UNTIL THE FILING OF FOR	M WC-2 V										IONS. A	ALL OT	THER SU	SPENSION	NS REQUIRE
C. NOTICE	тос	ONTROV	ERT P	AYMENT	OF C	OMPE	NSATIO	N							
Benefits will not be paid 0198+0197	oecause:													_	
□ D. MEDICA	AL ONL	Y INJUF	RY (No in	ndemnity b	enefits	are due	and/or h	ave I	NOT bee	n contro	overted	l.)			
Insurer / Self-Insurer: T	ype or Print	Name of Pers	on Filing For	m		Signature 0140								Date File Da	te
Phone Number From party table						E-mail From	Party Tal	le							



EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

	URE 1	ro subn	AIT THIS RI	EPORT TO	INSURER	MMEDIA	TELY MAY					E TYP	ED OR	PRINT	TED IN	BLACK INK.	
Board Claim No.				oyee Last N +0255(IA)	lame			004		First Name	е			M.I. 0045	5	Date of Injury	
A. IDENTIF	YIN	G INFO	ORMATI	ON				_									
EMPLOYEE		Male ₀₀₅₃ Female	Birthdate 0052			Phone N 0051	lumber			Employ X	ee E-mail						
Mailing Address 0046+0047(IA)							С	0048					State 0049	1	Zip Coc	0050	
EMPLOYER	Name	0018					V	NAICS Code	9		Nature o					Mfg.,etc.)	
Mailing Address 0168+0169(IA)							Р	hone Numb	er						mplove 0016	er FEIN	
City 0165				State 0170	Zip Co. 0167	de	Е	mployer E-ı	mail								
INSURER / SELF-INSURE	R	Name	0007				In	nsurer/Self-I	nsurer	FEIN			Insure 0015	er/ Self-I	nsurer	File #	
CLAIMS OFFIC	E	Name	0188			Claims 0187	Office FEIN :	#	A CONTRACTOR	ns Office Pl m Party T			7,000	s Office n Party			
SBWC ID# (five digit			Mailing Ad 0010+00				С	0012					tate 0013		Zip Cod	0014	
EMPLOYMENT		999	Date Hired by	Employer	Job Classifi	ed Code N	lo.	Numbe 0064	- 65	ys Worked F	Per Week			ate at tir r Diseas		per Hour = per Day = per Week	=06
Insurer Type Code		m party Tabl		und	List N	Iormally So	cheduled Day	0204	=S=Sat =F,V= \							per Month	
INJURY/ILLNE & MEDICAL	ss	Time o	f Injury 003	2 am	County of Ir	njury			Ir	Date Employ njury 0040	yer had kno	wledge	of	Enter F a Full [0056	Day	te Employee Failed t	o Work
Did Employee Receir Pay on Date of Injury Yes	/? 0066 No	on E		Occur 0249 emises' Lorx	Type of Inju	ry/Iliness					Body F	Part Affe	ected				
How Injury or Illness	/ Abno	rmal Healt	h Condition C	ccurred													
Treating Physician (Name a	and Addres	ss)		reatment Giver	0039		250	acility (Name and /	Address)	If Re	eturned t	to Work,	, Give E	Date: X	
Х				_	/linor: By Emp /linor: Clinical/		X					Retu	urned at	what wa	age	X pe	er Week
				_	mergency Ro łospitalized >								ital, Ente		lete	0057	
Report Prepared By 0160	(Print o	r Type)									Telephone	e Numbe	er			Date of Report	
✓ B. INCO	ME	BENE	FITS Fo	rm WC-6	must be f	iled if w	eekly be	nefit is l	ess tl	han max	imum				•		
Previously Medical C			ge Weekly \	2000 FB.	0286			ekly benef		0134					of disa 4 Or 0		
Date of first Payn	nent:	0192		Compe	nsation paid	: \$ 008	86		or Date	e salary pa	aid:			Per	nalty p	aid: \$	
BENEFITS ARE F			M00	88		FOR:						On	ly for 03	0			
☐ Temporary to 050 UNTIL	otal dis	ability	070		rtial disabilit	030)	ent partial		lility of	-	% to	0083			for 0090 N	weeks.
THE FILING OF F	ORM	WC-2 W											N. Alexandri (Simil				1.3100
☐ C. NOTI			NTROV	ERT PA	AYMENT	OF C	OMPEN	ISATIO	N								
Benefits will not be p	aid bed	ause:															
□ D. MEDI	CAL	ONL	Y INJUF	RY (No in	demnity b	enefits	are due a	and/or h	ave N	OT bee	n contro	verte	d.)				
Insurer / Self-Insure	er: Type	e or Print N	Name of Perso	on Filing Forr	m		Signature 0140									Date File Date	
Phone Number 0137	ī						E-mail 0139										



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYN	IENT V RE-C	OMMENCE	SUSPEND A		VC-2 Date	
Board Claim No.	Employee 0043+0	Last Name 255(IA)	Employee Fir	st Name	M.I. 004	Date of Injury 0031
		A. IDEN	TIFYING INFORMA	TION		
EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA			
City	SI	ate Zip Code	City	9	State	e Zip Code
0048 Employee E-mail	00	49 0050	0165 Employer E-mail		017	0 0167
Employee E mail			Employor E mail			
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insure	0015	97	
CLAIMS OFFICE	Name 0188		Claims Office E-ma		State	Zip Code
SBWC ID#	Mailing Address	0044048	City	Tubic	State	Zip Code
From Party table	0010-	F00119(IA)	0012		0013	0014
		B. II	NCOME BENEFITS			
Benefits are being paid to t	his employee at the rate	of 0134	*per week t	based on an average weekly w	vage of \$	00286
payable from 0088	1 1	for:	if BTC=070, static map	"VARIES"		2
☐ Temporary Total Disabi						
☐ Temporary Partial Disal				0090		ONLY FOR BTC=030
Permanent Partial Disal	oility of 0084 %	to 0083 (Part of Bo	to be paid for	weeks	(medical re	port attached).
Date of Disability 0056		(Fait of Bo	ody)			
The date of the first check i	0192(BTC=050,070,	030) the ar	nount is \$ 0086/BTC-050 070 0	030) , or date salary was paid	4 0000 (BTC	=250) and this:
Does not include a pena	J	, tile all	110ditt is \$ 0000(<u>B1C=000,070,0</u>	o) , or date salary was paid	1 0000 (510	and this.
☐ Does include a 15		mount of \$ if 0216 has 3	10=0215			
			tatement, if weekly benefit is l	ess than maximum.		
		C. SUS	PENSION OF BEN	IEFITS		
Benefits will be suspe	nded on		because:			
1.) Employee returne	d to work on		without res	strictions from the authorized	d treating phy	/sician.
2.) Employee returne	£		3			e-injury or higher rate of pay.
the state of the s	porary partial disability b	enefits are shown in Pa		m the authorized treating ph	ysician at rec	Juced pay or \$
	le to return to work on			triations from the outherized	l tracting phy	cicion, the empleyee is being
A		zed treating physician's	report is attached (Board R		treating priys	sician, the employee is being
 5.) The employee had catastrophic injury 	d undergone a change in y, has been determined ecutive or 78 aggregate v	n condition pursuant to C by the authorized treatin	D.C.G.A. § 34-9-104(a) (2) being physician to be capable o	ecause the employee is not if performing work with limita s of the release. Temporary	ations or restr	rictions for
☐ 6.) The employee has	s been offered suitable e			as unjustifiably refused to att ne Form WC-240 is attache		orm the job. Form WC-240
			mporary total disability paym			
State of the state	nent partial disability ben	THE ROLL OF THE CAMPAGENESS OF WATER 1. THE RESIDENCE OF				
	temporary partial disabili	(f. 6, 8)		orm WC-3 simultaneously	and sond a	conv to the employee
☐ 10.) This claim is bein☐ 11.) Other:	g controverted within SIX	ty days of the due date	or mat payment. File the Fo	Ann WC-3 Simultaneously	anu senu a	copy to the employee.
357750 Data and #000000000000000000000000000000000000	· N					15.
Insurer/Self-Insurer Type or Prii 0140	il iname		Signature 0140			Date File Date
Phone Number			E-mail			
0137			0138			
This form must be filed w	ith the State Board of W	orkers' Compensation	A copy of both sides of this	form has been sent to the cl	laimant(s) an	d all counsel of record

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYME	ENT V RE-COMMENCE	/ SUSP		VC-1 Dat VC-2 Dat							
Board Claim No.	Employee Last Name 0043+0255(IA)		Employee First Name	M.I 004							
	A. IDEN	ITIFYING	INFORMATION								
EMPLOYEE			EMPLOYER Name 0018								
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)								
City 0048	State Zip Code 0049 005	0	City 0165	Sta 01	100 C C C C C C C C C C C C C C C C C C						
Employee E-mail	0043	741	Employer E-mail		0101						
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insurer File # 0015								
CLAIMS OFFICE	Name 0188		Claims Office E-mail From Party Table	State	Zip Code						
SBWC ID# From Party table	Mailing Address 0010+00119(IA)		O012	State 0013	Zip Code 0014						
	B.	INCOME	BENEFITS								
Benefits are being paid to this	s employee at the rate of 0134 or		*per week based on an average weekly w	age of \$	00286						
payable from 0088 Temporary Total Disability Temporary Partial Disabili	/ BTC=050/250	or: if BT	C=070, static map "VARIES"		ONLY FOR BTC=030						
200	Permanent Partial Disability of 0084 % to 0083 to be paid for 0090 weeks (medical report attached).										
Date of Disability 0056		,,									
The date of the first check is, Does not include a penalty		amount is \$ (0086(<u>BTC=050,070,03</u> 0) , or date salary was paid	0088 (BT	C=250) and this:						
☐ Does include a 15	% penalty in the amount of \$ if 0216 has	100 mm and 100 mm	 weekly benefit is less than maximum.								
			ON OF BENEFITS								
Benefits will be suspend	ded on 0089(Active benefits that was previous	s reported)	because:								
☐ 1.) Employee returned t	to work on		without restrictions from the authorized	treating ph	nysician.						
2.) Employee returned t	to work on	wi	th restrictions from the authorized treating ph	ysician at p	re-injury or higher rate of pay.						
3.) Employee returned to per week and temporary.	to work on orary partial disability benefits are shown in F	- 10	th restrictions from the authorized treating ph	ysician at re	educed pay of \$						
☐ 4.) Employee was able			without restrictions from the authorized	treating phy	ysician, the employee is being						
given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)). 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.											
	6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. A copy of the Form WC-240 is attached.										
	strophic injury and the maximum number of t	emporary tot	tal disability payments has been paid.								
Se to the comment of	nt partial disability benefit has been paid. mporary partial disability payments has been	paid.									
and the second of the second		THE SHARE OF	ment. File the Form WC-3 simultaneously	and send a	copy to the employee.						
11.) Other: Change In Bo	enefit + 0233										
Insurer/Self-Insurer Type or Print I 0140	Name	Signature 0140			Date File Date						
Phone Number 0137		E-mail 0138									
This form must be filed with	the State Board of Workers' Compensation	. A copy of b	ooth sides of this form has been sent to the c	laimant(s) a	nd all counsel of record.						



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

INITIAL PAY	MENT - R	E-COMMENCE	SUSP	END A		NC-1 Date			
Board Claim No. 0005		oyee Last Name 13 +0255(IA)		Employee Fir	rst Name	M.I. 004			
		A. IDEI	NTIFYING	INFORMA	TION				
EMPLOYEE				EMPLOYER	Name 0018				
Mailing Address				Mailing Address	1)				
0046+0047(IA) City		State Zip Code	:0	0168+0169(IA City 0165	*)	State			
0048 Employee E-mail		0049	00	Employer E-mail		017	70 0167		
INSURER/	Name 0007			Insurer/Self-Insure	er File # 0015				
SELF-INSURER CLAIMS OFFICE	Name 0188			Claims Office E-m		State	Zip Code		
SBWC ID#	Mailing Address	010+00119(IA)		City 0012	y I able	State	Zip Code		
From Party table	V		INICOME			0013	0014		
		0134	INCOME	BENEFITS	<u> </u>		00000		
Benefits are being paid to	this employee at the	rate of		*per week l	based on an average weekly v	wage of \$	00286		
☐ Temporary Total Disab ☐ Temporary Partial Disa ☐ Permanent Partial Disa ☐ Date of Disability ☐ The date of the first check ☐ Does not include a pen ☐ Does include a ☐ 15	bility BTC=070 bility of 0084 is, 0192(BTC=050 alty if 0216 <>310	% to 0083 (Part of	amount is \$ (030) , or date salary was paid		ONLY FOR BTC=030 eport attached). C=250) and this:		
		C. SU	JSPENSI(ON OF BEN	IEFITS				
Benefits will be suspe	ended on			because:					
☐ 1.) Employee returne	ed to work on			without res	strictions from the authorized	d treating phy	ysician.		
2.) Employee returne	ed to work on		wi	th restrictions fro	om the authorized treating ph	nysician at pre	re-injury or higher rate of pay.		
3.) Employee returns	2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	lity honofite are shown in			om the authorized treating ph	nysician at red	duced pay of \$		
4.) Employee was ab given ten (10) day 5.) The employee ha catastrophic injur the past 52 consi	4.) Employee was able to return to work on without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)). 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.								
					as unjustifiably refused to at he Form WC-240 is attache		orm the job. Form WC-240		
7.) This was not a ca	tastrophic injury and	I the maximum number of	550,881.0000000000000000000000000000000000						
	ACTUAL TO BE REAL OF THE PARTY	r benefit has been paid. sability payments has beer	n paid.						
			· · · · · · · · · · · · · · · · · · ·	ment. File the Fe	orm WC-3 simultaneously	and send a	copy to the employee.		
☐ 11.) Other:									
Insurer/Self-Insurer Type or Pr 0140	int Name		Signature 0140				Date File Date		
Phone Number 0137			E-mail 0138				- 1		
This form must be filed w	vith the State Board	of Workers' Compensation	n. A copy of b	ooth sides of this	form has been sent to the c	laimant(s) an	nd all counsel of record.		



NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

Employee First Name 0044	M.I. 0045	Date of Injury								
TIFYING INFORMATION										
EMPLOYER Name										
Mailing Address										
0168+0169(IA)	1 22/07	1-2								
		Zip Code 0167								
Employer E-mail	,,,,,									
Insurer/Self-Insurer File # 0015										
Claims Office E-mail	State	Zip Code								
City	State	Zip Code								
ELEC	0013	0014								
NCOME BENEFITS										
*per week based on an average weekly w	age of \$	00286								
if BTC=070, static map "VARIES"										
☐ Temporary Partial Disability BTC=070 ☐ Permanent Partial Disability of 0084 % to 0083 to be paid for weeks (medical report attached).										
to be paid for weeks	(medical repo	ort attached).								
ody)										
mount is \$ 0086(BTC=050,070,030) , or date salary was paid	0088 (BTC=2	250) and this:								
.,										
310=0215										
THE COLUMN TO SERVE THE COLUMN TO SERVE AS										
PENSION OF BENEFITS										
because:										
without restrictions from the authorized	treating physi	cian.								
	y sician at read									
without restrictions from the authorized	treating physic	rian the employee is being								
	areating project	dan, the employee to being								
5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.										
		m the job. Form WC-240								
mporary total disability payments has been paid.										
and d										
	and send a co	ony to the employee								
or mat payment. The the Form WO-3 simultaneously	unu senu a cc	py to the employee.								
Signature		Date								
0140		File Date								
4										
E-mail 0138		<u> </u>								
	Employee First Name 0044 TIFYING INFORMATION EMPLOYER Mailing Address 0168+0169(IA) City 0165 Employer E-mail From Party Table City 0012 NCOME BENEFITS "per week based on an average weekly weeks based on an average weekly were." if BTC=070, static map "VARIES" to be paid for 0090 weeks word if Benefit is less than maximum. SPENSION OF BENEFITS because: without restrictions from the authorized treating pheart B above. with restrictions from the authorized treating pheart B above. without restrictions from the authorized is report is attached (Board Rule 221 (i)(4)). O.C.G.A. § 34-9-104(a) (2) because the employee is not ng physician to be capable of performing work with limita orm WC-104 within sixty days of the release. Temporary to a concept of the release. Temporary to a concept of the Form WC-240 is attached emporary total disability payments has been paid. paid. signature	Employee First Name 0044 Employee First Name 0045 TIFYING INFORMATION EMPLOYER Mailing Address 01684-0169(IA) City 0165 Employer E-mail Insurer/Self-Insurer File # 0015 Claims Office E-mail From Party Table City 0012 NCOME BENEFITS "per week based on an average weekly wage of \$ ". If BTC=070, static map "VARIES" to be paid for								

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

□ INITIAL PAYM	IENT - RE	E-COMMENCE 🔻		WC-1 Date	
Board Claim No.	10101010	oyee Last Name I3+0255(IA)	Employee First Name 0044	M.I. 004	. Date of Injury
		A. IDEN	TIFYING INFORMATION		
EMPLOYEE			EMPLOYER Name		
Mailing Address			Mailing Address		
0046+0047(IA)			0168+0169(IA)		
City 0048		State Zip Code 0050	City 0165	Stat 017	
Employee E-mail		0049	Employer E-mail	011	0107
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insurer File # 0015		
CLAIMS OFFICE	Name 0188		Claims Office E-mail	State	Zip Code
SBWC ID#	Mailing Address		From Party Table City	State	Zip Code
From Party table	00	010+00119(IA)	0012	0013	0014
		B. I	NCOME BENEFITS		
Benefits are being paid to the	nis employee at the	rate of	*per week based on an average weekly	wage of \$	y
payable from	1		-		
☐ Temporary Total Disabili	ity				
☐ Temporary Partial Disab					
☐ Permanent Partial Disab	ility of	% to(Part of B	to be paid for weel	s (medical re	eport attached).
Date of Disability		_	,		
The date of the first check is	3,	, the ar	mount is \$, or date salary was pa	iid	and this:
☐ Does not include a pena	lty				
Does include a	% penalty in t	the amount of \$			
		COL CONTRIBUTE (\$10 NO LIST, C. COLL) FOR PERCENCIAL COLL.	Statement, if weekly benefit is less than maximum.		
		C. SUS	SPENSION OF BENEFITS		
Benefits will be susper	nded on 0193	1	because:		
1.) Employee returned	I to work on 0189/	A & 0224/N>\$1<0072/ If NA	then 0068 without restrictions from the authoriz	ed treating ph	ysician. OR
2.) Employee returned	to work on 0189/	A & 0224/Y>\$1<0072/ If NA	then 0068 with restrictions from the authorized treating p	hysician at pi	re-injury or higher rate of pay.
☐ 3.) Employee returned	to work on		with restrictions from the authorized treating p	hysician at re	educed pay of \$
per week and temp	orary partial disabil	ility benefits are shown in Pa	art B above.		
☐ 4.) Employee was able			without restrictions from the authorize	d treating phy	sician, the employee is being
The second secon	notice, and the au	thorized treating physician's	s report is attached (Board Rule 221 (i)(4)).		
			O.C.G.A. § 34-9-104(a) (2) because the employee is no ng physician to be capable of performing work with limi		
the past 52 conse	cutive or 78 aggreg		orm WC-104 within sixty days of the release. Tempora		
are shown above 6.) The employee has		ble employment nursuant to	O.C.G.A. § 34-9-240 and has unjustifiably refused to a	ettempt to perf	form the job. Form WC-240
			report for work. A copy of the Form WC-240 is attack		om the job. I om We 240
The second secon			emporary total disability payments has been paid.		
De la companya de la	CANADA SANCE CONTRACTOR CONTRACTO	benefit has been paid.	naid		
The second second second second second	11 m (5 May by 1977)	sability payments has been pain sixty days of the due date	paid. of first payment. File the Form WC-3 simultaneousl	v and send a	copy to the employee
			action in 0072 or 0068> + < Narrative-0233 (If Available)	, эспа а	to and employee.
Insurer/Self-Insurer Type or Prin	~		Signature		Date
0140			0140		File Date
Phone Number			E-mail		
0137			0138		
This form must be filed wi	th the State Board	of Workers' Compensation	A conv of both sides of this form has been sent to the	claimant(e) ar	nd all counsel of record

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

□ INITIAL PAYM	ENT RE-COMMENCE		WC-1 Date							
Board Claim No.	Employee Last Name 0043+0255(IA)	Employee First Name 0044	M.I. 004	Date of Injury						
	A. IDE	NTIFYING INFORMATION								
EMPLOYEE	TA 75-200-200-00	Name								
Mailing Address		Mailing Address								
0046+0047(IA)		0168+0169(IA)								
City	State Zip Code	City 0165	State							
0048 Employee E-mail	0049	Employer E-mail	017	0 0167						
W-Stone Const. The Const. Cons		Control of Section Adjustment Control of Con								
INSURER/ SELF-INSURER	Name 0007	Insurer/Self-Insurer File # 0015								
CLAIMS OFFICE	Name 0188	Claims Office E-mail	State	Zip Code						
SBWC ID#	Mailing Address	From Party Table City	State	Zip Code						
From Party table	0010+00119(IA)	0012	0013	0014						
8	В.	INCOME BENEFITS								
Renefits are being paid to the	is employee at the rate of	*per week based on an average weekly	/ wage of \$							
Valent Control I to Control Annual Printer Control Annual Control	1	for:	, viage II.	<u> </u>						
□ Temporary Total Disabilit		IOI.								
☐ Temporary Partial Disabil										
Permanent Partial Disabi	ility of % to	to be paid for wee	ks (medical re	port attached).						
	(Part of	Body)								
Date of Disability										
The date of the first check is		amount is \$, or date salary was pa	aid	and this:						
☐ Does not include a penal	ty									
Does include a	% penalty in the amount of \$	The state of the s								
	SIGNAL DOCKSTRADOS TRACES NOS AND A 12 TO \$ \$200 A 2010 TO	e Statement, if weekly benefit is less than maximum.								
		JSPENSION OF BENEFITS								
Benefits will be suspend	ded on 0193	because:								
1.) Employee returned	to work on 0189/A & 0224/N>\$1<0072/ If N	Without restrictions from the authoriz	ed treating phy	rsician. OR						
2.) Employee returned	to work on 0189/A & 0224/Y>\$1<0072/ If N	A then 0068 with restrictions from the authorized treating	physician at pre	e-injury or higher rate of pay.						
3.) Employee returned		with restrictions from the authorized treating								
A STATE OF THE PROPERTY OF THE	orary partial disability benefits are shown in		pii) 5.5.c							
4.) Employee was able	to return to work on	without restrictions from the authorize	ed treating phys	sician the employee is being						
	·	n's report is attached (Board Rule 221 (i)(4)).	ed treating proje	sicials, the employee to be						
☐ 5.) The employee had	undergone a change in condition pursuant t	o O.C.G.A. § 34-9-104(a) (2) because the employee is no								
		ating physician to be capable of performing work with lim Form WC-104 within sixty days of the release. Tempora								
are shown above in		FOITH WC-104 WILLIEF SIXTY days of the release. Tempore	ily partial disas	ility belients						
		to O.C.G.A. § 34-9-240 and has unjustifiably refused to a preport for work. A copy of the Form WC-240 is attack		orm the job. Form WC-240						
The contract of the contract o		temporary total disability payments has been paid.	neu.							
8.) The entire permanent partial disability benefit has been paid.										
9.) The maximum of te	mporary partial disability payments has bee	n paid.								
	10.) This claim is being controverted within sixty days of the due date of first payment. File the Form WC-3 simultaneously and send a copy to the employee.									
11.) Other: If 0189/R the	n "Release to RTW") = "DATE" < date from tra	nsaction in 0072 or 0068> + < Narrative-0233 (If Available)								
Insurer/Self-Insurer Type or Print	Name	Signature		Date						
0140		0140		File Date						
Phone Number		E-mail		1						
0137		0138	PAGE 1845							
This form must be filed wit	h the State Board of Workers' Compensation	n A conv of both sides of this form has been sent to the	claimant(e) an	d all counsel of record						



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

□ INITIAL PAYMENT □ RE-COMMENCE ■		WC-1 Dated WC-2 Dated								
Board Claim No. Employee Last Name 0005 0043+0255(IA)	Employee First Name 0044	M.I. 0045	Date of Injury 0031							
A. IDEN	TIFYING INFORMATION									
EMPLOYEE	EMPLOYER Name									
Mailing Address	Mailing Address									
0046+0047(IA)	0168+0169(IA)		V- 400 - 10 - 10							
City State Zip Code 0049 0050	City 0165	State 0170	Zip Code 0167							
Employee E-mail	Employer E-mail	0110	0101							
INSURER/ SELF-INSURER Name 0007	Insurer/Self-Insurer File #									
CLAIMS OFFICE Name 0188	Claims Office E-mail	State	Zip Code							
SBWC ID# Mailing Address	From Party Table City	State	Zip Code							
From Party table 0010+00119(IA)	0012	0013	0014							
B. II	NCOME BENEFITS									
Benefits are being paid to this employee at the rate of *per week based on an average weekly wage of \$										
payable from / / for:										
☐ Temporary Total Disability										
☐ Temporary Partial Disability										
Permanent Partial Disability of % to to be paid for weeks (medical report attached).										
Date of Disability										
The date of the first check is,, the an	nount is \$, or date salary was pa	id	and this:							
☐ Does not include a penalty										
☐ Does include a % penalty in the amount of \$										
	statement, if weekly benefit is less than maximum.									
0400										
beriefits will be suspended on	because:	200 25 10 1								
	without restrictions from the authorize									
2.) Employee returned to work on	with restrictions from the authorized treating p	hysician at pre-	injury or higher rate of pay.							
3.) Employee returned to work on	with restrictions from the authorized treating p	hysician at redu	iced pay of \$							
per week and temporary partial disability benefits are shown in Pa	rt B above.									
4.) Employee was able to return to work on	without restrictions from the authorize	d treating physic	cian, the employee is being							
given ten (10) days notice, and the authorized treating physician's 5.) The employee had undergone a change in condition pursuant to 0		tworking did n	ot have a							
catastrophic injury, has been determined by the authorized treating	ng physician to be capable of performing work with limit	tations or restric	tions for							
the past 52 consecutive or 78 aggregate weeks, and was sent Fo are shown above in part B above.	rm WC-104 within sixty days of the release. Temporar	y partial disabili	ty benefits							
6.) The employee has been offered suitable employment pursuant to			m the job. Form WC-240							
was sent at least ten days before the employee was required to report for work. A copy of the Form WC-240 is attached. 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.										
8.) The entire permanent partial disability benefit has been paid.	5.50 5									
$\ \square$ 9.) The maximum of temporary partial disability payments has been p	aid.									
10.) This claim is being controverted within sixty days of the due date of first payment. File the Form WC-3 simultaneously and send a copy to the employee.										
11.) Other: "Medical Non-Compliance"+ "RTW DATE" <date from="" of="" state="" state<="" td="" the=""><td>om transaction in 0072 or 0068> (if applicable) +</td><td>+0233</td><td></td></date>	om transaction in 0072 or 0068> (if applicable) +	+0233								
Insurer/Self-Insurer Type or Print Name	Signature		Date							
0140	0140		File Date							
Phone Number 0137	E-mail 0138									
This form must be filed with the State Board of Workers' Compensation	100 000 000 000 000 000 000 000 000 000	claimant(s) and	all soumed of record							

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYM	IENT 🗆 RI	E-COMMENCE 🗣	SUSPEND - A		/C-1 Dated /C-2 Dated					
Board Claim No.	10000000000000000000000000000000000000	oyee Last Name I3+0255(IA)	Employee Firs	st Name	M.I. 0045	Date of Injury 0031				
		A. IDEN	TIFYING INFORMA	TION						
EMPLOYEE			EMPLOYER	Name 0018						
Mailing Address			Mailing Address	0010						
0046+0047(IA)			0168+0169(IA)		The state of the state of				
City 0048		State Zip Code 0050	City 0165		State 0170	Zip Code 0167				
Employee E-mail		0043	Employer E-mail		0110	0107				
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insurer	r File # 0015						
CLAIMS OFFICE	Name 0188		Claims Office E-ma		State	Zip Code				
SBWC ID#	Mailing Address		From Party City	Table	State	Zip Code				
From Party table	0	010+00119(IA)	0012		0013	0014				
9 9		В. І	NCOME BENEFITS	0						
Benefits are being paid to the	nis employee at the	rate of	*per week b	pased on an average weekly w	age of \$					
				•	J .					
payable from / / for: ☐ Temporary Total Disability										
☐ Temporary Partial Disab	ility									
Permanent Partial Disability of % to to be paid for weeks (medical report attached).										
Date of Disability	CONTRACTOR OF STANDARD CONTRACTOR									
The date of the first check is		, the ar	mount is \$	_ , or date salary was paid		and this:				
Does not include a pena	lty									
☐ Does include a	% penalty in t	the amount of \$ *File Form WC-6, Wage 5	Statement, if weekly benefit is le	ess than maximum						
			SPENSION OF BEN							
Benefits will be susper	nded on 019	03	because:							
☐ 1.) Employee returned	I to work on		without res	trictions from the authorized	treating phys	sician.				
2.) Employee returned			with restrictions from							
☐ 3.) Employee returned				m the authorized treating phy						
/		lity benefits are shown in Pa		in the datherized treating pri	y ololait at roa					
4.) Employee was able	e to return to work	on	without rest	trictions from the authorized	treating phys	ician, the employee is being				
			report is attached (Board Ru			eran, me empreyee te semig				
catastrophic injury the past 52 conse	, has been determi cutive or 78 aggreg	ned by the authorized treating	O.C.G.A. § 34-9-104(a) (2) being physician to be capable of form WC-104 within sixty days	f performing work with limitat	tions or restric	ctions for				
	been offered suita		O.C.G.A. § 34-9-240 and ha			m the job. Form WC-240				
THE PARTY OF THE P			mporary total disability paym		u.					
		benefit has been paid.								
	0 (5 0)	sability payments has been p								
			of first payment. File the Fo			opy to the employee.				
11.) Other: Administrative Non- Compliance+RTW DATE <date 0068="" 0072="" from="" in="" or="" transaction=""> (if applicable) +0233</date>										
Insurer/Self-Insurer Type or Prin	t Name		Signature			Date				
0140			0140			File Date				
Phone Number 0137			E-mail 0138							
0137 O138 This form must be filed with the State Board of Workers' Companyation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record										

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYM	IENT 🗆 RE	E-COMMENCE 🛶	SUSPEND A		VC-1 Date VC-2 Date						
Board Claim No.	***************************************	oyee Last Name 3+0255(IA)	Employee Fir		M.I. 0045	Date of Injury					
v 0		A. IDEN	TIFYING INFORMA	TION							
EMPLOYEE Mailing Address			EMPLOYER Mailing Address	Name 0018							
0046+0047(IA)			0168+0169(IA	()							
City 0048		State Zip Code 0050	City 0165		State 0170	100 TO CHECKER OF THE CONTROL OF THE					
Employee E-mail		0043	Employer E-mail								
INSURER/ SELF-INSURER Name 0007 Insurer/Self-Insurer File # 0015											
CLAIMS OFFICE	Name 0188		Claims Office E-m From Party		State	Zip Code					
SBWC ID# From Party table	Mailing Address	010+00119(IA)	City 0012	Table	State 0013	Zip Code 0014					
	•	В. І	NCOME BENEFITS								
Benefits are being paid to this employee at the rate of*per week based on an average weekly wage of \$ payable from / for: Temporary Total Disability Temporary Partial Disability Permanent Partial Disability of % to to be paid for weeks (medical report attached). (Part of Body)											
Date of Disability		_									
The date of the first check is		, the ar	mount is \$, or date salary was paid	i	and this:					
Does include a	% penalty in t	he amount of \$ *File Form WC-6. Wage \$	Statement, if weekly benefit is l	ess than maximum.							
			PENSION OF BEN	2007 (1907)							
Benefits will be susper	nded on019		because:	1 1000 (0000)							
☐ 1.) Employee returned	i to work on		without res	strictions from the authorized	treating phy	sician.					
2.) Employee returned	to work on		with restrictions fro	m the authorized treating phy	ysician at pre	injury or higher rate of pay.					
☐ 3.) Employee returned	and the second s			m the authorized treating phy	ysician at red	luced pay of \$					
	orary partial disabi	lity benefits are shown in Pa									
4.) Employee was abl			without res report is attached (Board R		treating phys	sician, the employee is being					
 5.) The employee had catastrophic injury 	d undergone a chang , has been determin cutive or 78 aggreg	ge in condition pursuant to 0 ned by the authorized treatin	D.C.G.A. § 34-9-104(a) (2) b ng physician to be capable o	ecause the employee is not of performing work with limital s of the release. Temporary	tions or restri	ictions for					
				as unjustifiably refused to atte ne Form WC-240 is attache		rm the job. Form WC-240					
E_D			mporary total disability payn								
Service Control of the Control of th		benefit has been paid.	1-1								
		ability payments has been p n sixty days of the due date		orm WC-3 simultaneously a	and send a (copy to the employee.					
11.) Other: Claimant	- Control of the Cont		osanovino mente de mingraphico de esta esta esta esta esta esta esta est	overver (MZCOOM), COUNTY (STREET)	provide a description of the second						
Insurer/Self-Insurer Type or Prin	nt Name		Signature			Date					
0140			0140			File Date					
Phone Number 0137			E-mail 0138								
1000000 Mass	ith the State Board	of Workers' Compensation.	5	form has been sent to the cl	laimant(s) and	d all counsel of record.					

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYM	ENT 🗆 RE	E-COMMENCE 🛶	SUSPEND A		/C-1 Dated /C-2 Dated						
Board Claim No.	11020200	oyee Last Name 3+0255(IA)	Employee Fin	st Name	M.I. 0045	Date of Injury					
		A. IDEN	TIFYING INFORMA	TION							
EMPLOYEE			EMPLOYER	Name 0018							
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA	()							
City 0048		State Zip Code 0050	City 0165	-	State 0170	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1					
Employee E-mail		0043	Employer E-mail		0110	0101					
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insure	or File # 0015							
CLAIMS OFFICE	Name 0188		Claims Office E-ma		State	Zip Code					
SBWC ID# From Party table	Mailing Address	010+00119(IA)	City 0012	Table	State 0013	Zip Code 0014					
Trom rury capic		B. II	NCOME BENEFITS		0010	0014					
Benefits are being paid to this employee at the rate of*per week based on an average weekly wage of \$											
payable from / / for: Temporary Total Disability to be paid for weeks (medical report attached). Permanent Partial Disability to be paid for weeks (medical report attached). Permanent Partial Disability to be paid for weeks (medical report attached). Date of Disability											
		C. SUS	PENSION OF BEN	EFITS							
Benefits will be suspen	ided on 019	3	because:								
1.) Employee returned	to work on		without res	strictions from the authorized	treating phys	sician.					
2.) Employee returned	to work on		with restrictions from	m the authorized treating phy	ysician at pre	-injury or higher rate of pay.					
3.) Employee returned ner week and temp	The second secon	lity henefits are shown in Pa		m the authorized treating phy	ysician at red	uced pay of \$					
4.) Employee was able to return to work on without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)). 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above. 6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. A copy of the Form WC-240 is attached. 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid. 8.) The entire permanent partial disability payments has been paid. 9.) The maximum of temporary partial disability payments has been paid. 10.) This claim is being controverted within sixty days of the due date of first payment. File the Form WC-3 simultaneously and send a copy to the employee. 11.) Other: Claimant incarceration +233											
Insurer/Self-Insurer Type or Prin 0140	i indiffe		Signature 0140			Pate File Date					
Phone Number 0137			E-mail 0138			1					
This form must be filed wit	th the State Board	of Workers' Compensation.	A copy of both sides of this	form has been sent to the cla	aimant(s) and	all counsel of record.					



NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYM	IENT 🗆 RI	E-COM	MENCE 📝	SUSPEN		AMENDMEN		VC-1 Dat VC-2 Dat		
Board Claim No.	130000 30 000	oyee Last I 3 +0255(I			mployee Fi	irst Name		M.I 00	Comment of the Commen	Date of Injury
			A. IDENT	IFYING IN	FORM/	ATION				
EMPLOYEE					PLOYER	Name				
Mailing Address 0046+0047(IA)					ng Address 8 8+0169(l .					
City 0048		State 0049	Zip Code 0050	City	0165			Sta 01	200	ip Code 0167
Employee E-mail		0049		Em	loyer E-mail	4		01	10	0107
INSURER/ SELF-INSURER	Name 0007			Insu	er/Self-Insur	rer File # 0015				
CLAIMS OFFICE	Name 0188			Clai	ns Office E-n From Part			State	Zip	Code
SBWC ID# From Party table	Mailing Address 0	010+0011	19(IA)	City	0012			State 0013		Code 014
			B. IN	COME B	NEFITS	S				
Benefits are being paid to this employee at the rate of*per week based on an average weekly wage of \$										
□ Temporary Partial Disability □ Permanent Partial Disability of										
			C. SUSI	PENSION	OF BEI	NEFITS				
Benefits will be susper	nded on 019	3		b	ecause:					
☐ 1.) Employee returned	to work on				without re	estrictions from th	e authorized	d treating ph	nysician	1.
2.) Employee returned	to work on			with re	strictions fro	om the authorized	d treating ph	ysician at p	re-injur	ry or higher rate of pay.
☐ 3.) Employee returned	to work on			with re	strictions fro	om the authorize	d treating ph	ysician at re	educed	pay of \$
per week and temporary partial disability benefits are shown in Part B above. 4.) Employee was able to return to work on without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)). 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above. 6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. A copy of the Form WC-240 is attached. 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid. 8.) The entire permanent partial disability benefit has been paid. 9.) The maximum of temporary partial disability payments has been paid. 10.) This claim is being controverted within sixty days of the due date of first payment. File the Form WC-3 simultaneously and send a copy to the employee.										
11.) Other: Claimant Whereabouts Unknown +233										
Insurer/Self-Insurer Type or Prin	t Name			Signature 0140						Date File Date
Phone Number 0137				E-mail 0138						
This form must be filed w	th the State Board	of Workers	'Compensation A	5942 20A	ides of this	e form has been s	ent to the o	laimant(s) a	nd all o	counsel of record

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

□ INITIAL PAYM	ENT R	E-COMMENCE	SUSPEND AMENDMENT:	□ WC-1□ WC-2		·
Board Claim No.	West Con-	loyee Last Name 13+0255(IA)	Employee First Name 0044		M.I. 0045	Date of Injury
		A. IDEN	TIFYING INFORMATION			
EMPLOYEE		,	EMPLOYER Name			
Mailing Address			Mailing Address			
0046+0047(IA)		1 0 4 1 7 0 4	0168+0169(IA)		l ou i	7: 0.1
City 0048		State Zip Code 0050	O165		State 0170	Zip Code 0167
Employee E-mail			Employer E-mail		30	
INSURER/ SELF-INSURER	Name 0007		Insurer/Self-Insurer File # 0015			
CLAIMS OFFICE	Name 0188		Claims Office E-mail	State	e Z	Zip Code
SBWC ID#	Mailing Address	010+00119(IA)	City 0042	State		Zip Code
From Party table	0	1.05	0012	001	3	0014
		B. I	NCOME BENEFITS			
Benefits are being paid to th	is employee at the	rate of	*per week based on an average we	ekly wage of	\$	
payable from Temporary Total Disabili Temporary Partial Disab Permanent Partial Disab Date of Disability The date of the first check is Does not include a pena	ility ofs,	the amount of \$	to be paid for			
		C. SUS	SPENSION OF BENEFITS			
Benefits will be susper	ided on 019	93	because:			
☐ 1.) Employee returned	I to work on		without restrictions from the auth	orized treating	ng physici	ian.
2.) Employee returned	I to work on		with restrictions from the authorized treat	ing physiciar	n at pre-inj	jury or higher rate of pay.
☐ 3.) Employee returned	and the control of th		with restrictions from the authorized treat	ing physiciar	n at reduce	ed pay of \$
per week and temp	orary partial disab	ility benefits are shown in Pa	art B above.			
 5.) The employee had catastrophic injury 	notice, and the au undergone a char , has been determ cutive or 78 aggreg	uthorized treating physician's age in condition pursuant to ined by the authorized treati	without restrictions from the auth s report is attached (Board Rule 221 (i)(4)). O.C.G.A. § 34-9-104(a) (2) because the employee ng physician to be capable of performing work with orm WC-104 within sixty days of the release. Tem	is not working	ig, did not	have a
			O.C.G.A. § 34-9-240 and has unjustifiably refused report for work. A copy of the Form WC-240 is at		o perform	the job. Form WC-240
7.) This was not a cata 8.) The entire perman 9.) The maximum of te	astrophic injury and ent partial disability emporary partial dis	d the maximum number of te / benefit has been paid. \$7 sability payments has been	emporary total disability payments has been paid. (030)/ Or	S7(050) /Or		by to the employee.
Insurer/Self-Insurer Type or Prin	t Name		Signature			Date
0140 Phone Number			0140 E-mail			File Date
0137			0138			
This form must be filed wi	th the State Board	of Workers' Compensation.	A copy of both sides of this form has been sent to	the claiman	t(s) and al	Il counsel of record.

S8

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT	□ RE-COMMENCE ■		WC-1 Dated WC-2 Dated							
Board Claim No.	Employee Last Name 0043+0255(IA)	Employee First Name 0044	M.I. 0045	Date of Injury						
	A. IDEN	TIFYING INFORMATION								
EMPLOYEE		EMPLOYER Name								
Mailing Address		Mailing Address								
0046+0047(IA)		0168+0169(IA)								
City 0048	State Zip Code	City 0165	State 0170	Zip Code						
Employee E-mail	0049 0050	Employer E-mail	0170	0167						
INSURER/ Nam SELF-INSURER	e 0007	Insurer/Self-Insurer File # 0015								
CLAIMS OFFICE Nam	e 0188	Claims Office E-mail	State	Zip Code						
	ng Address	From Party Table	State	7in Codo						
From Party table	0010+00119(IA)	O012	0013	Zip Code 0014						
2	В. 1	INCOME BENEFITS		,						
Renefits are being paid to this emi	ployee at the rate of	*per week based on an average week	ly wage of \$							
	I fo		iy wago οι φ							
☐ Temporary Total Disability		и.								
☐ Temporary Partial Disability										
☐ Permanent Partial Disability of	% to	to be paid for we	eks (medical rep	oort attached).						
Country Indiana A Tables	(Part of B	Body)								
WATCH SOUTH TO SOUTH	Date of Disability									
The state of the s	, the a	amount is \$, or date salary was p	paid	and this:						
☐ Does not include a penalty										
Does include a 9	% penalty in the amount of \$									
	100 1880 AAN HERREZ PPO POPE POLVERO (1980 € 1900	Statement, if weekly benefit is less than maximum.								
		SPENSION OF BENEFITS								
Benefits will be suspended o	n 0193	because:								
1.) Employee returned to wo	rk on	without restrictions from the authori	zed treating phys	sician.						
2.) Employee returned to wo	rk on	with restrictions from the authorized treating	physician at pre	injury or higher rate of pay.						
3.) Employee returned to wo	rk on	with restrictions from the authorized treating	physician at red	uced pay of \$						
per week and temporary	partial disability benefits are shown in P	art B above.		2)						
4.) Employee was able to re	turn to work on	without restrictions from the authorize	zed treating phys	ician, the employee is being						
		's report is attached (Board Rule 221 (i)(4)).	01 ,	, , , ,						
		O.C.G.A. § 34-9-104(a) (2) because the employee is a								
		ing physician to be capable of performing work with lir form WC-104 within sixty days of the release. Tempor								
are shown above in part		, ,	0.5.cd	i.						
		o O.C.G.A. § 34-9-240 and has unjustifiably refused to report for work. A copy of the Form WC-240 is atta		rm the job. Form WC-240						
7.) This was not a catastropl	nic injury and the maximum number of to	emporary total disability payments has been paid.								
8.) The entire permanent partial disability benefit has been paid.										
and the state of t	ary partial disability payments has been	THE STATE OF THE S								
10.) This claim is being contr		e of first payment. File the Form WC-3 simultaneous	siy and send a d	opy to the employee.						
	yearsy was expressed.			T.a.						
Insurer/Self-Insurer Type or Print Name 0140		Signature 0140		Date File Date						
Phone Number		E-mail		i no Date						
0137		0138								
This form must be filed with the	State Board of Workers' Compensation	A conv of both sides of this form has been sent to th	o claimant(a) and	I all counsel of record						

SD

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ■		WC-1 Date								
Board Claim No. Employee Last Name 0005 0043+0255(IA)	Employee First Name 0044	M.I. 004	THE PERSON NAMED IN COLUMN							
A. IDEN	TIFYING INFORMATION									
EMPLOYEE	EMPLOYER Name									
Mailing Address 0046+0047(IA)	Mailing Address 0168+0169(IA)									
City State Zip Code 0048 0049 0050	City 0165	State 017	S (155,75) C135,750,7517							
Employee E-mail	Employer E-mail									
INSURER/ SELF-INSURER Name 0007 Insurer/Self-Insurer File # 0015										
CLAIMS OFFICE Name 0188	Claims Office E-mail From Party Table	State	Zip Code							
SBWC ID# Mailing Address From Party table 0010+00119(IA)	City 0012	State 0013	Zip Code 0014							
	NCOME BENEFITS		,							
Benefits are being paid to this employee at the rate of *per week based on an average weekly wage of \$										
payable from / for: Temporary Total Disability Permanent Partial Disability of % to to be paid for weeks (medical report attached). (Part of Body) Date of Disability The date of the first check is, , the amount is \$, or date salary was paid and this: Does not include a penalty Does include a % penalty in the amount of \$ File Form WC-6, Wage Statement, if weekly benefit is less than maximum.										
C. SUS	SPENSION OF BENEFITS									
Benefits will be suspended on0193	because:									
1.) Employee returned to work on	without restrictions from the authorize	d treating phy	sician.							
2.) Employee returned to work on	with restrictions from the authorized treating pl	hysician at pre	e-injury or higher rate of pay.							
S.) Employee returned to work on per week and temporary partial disability benefits are shown in Pa	with restrictions from the authorized treating plant B above.	hysician at red	duced pay of \$							
4.) Employee was able to return to work on without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)). 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above. 6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. A copy of the Form WC-240 is attached. 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid. 8.) The entire permanent partial disability benefit has been paid. 9.) The maximum of temporary partial disability payments has been paid. 10.) This claim is being controverted within sixty days of the due date of first payment. File the Form WC-3 simultaneously and send a copy to the employee.										
Insurer/Self-Insurer Type or Print Name 0140	Signature 0140		Date File Date							
Phone Number	E-mail		r no Date							
0137	0138 A copy of both sides of this form has been sent to the or	751700								

WC-2a

NOTICE OF PAYMENT / SUSPENSION OF DEATH BENEFITS



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

Board Claim No.	Employ 0043 0	yee Last Name	₩ 00	MINIENC		oyee First Na	me		M.I			f Injury
003	0043 0	200		A 15=::					00	+3	0031	
Name of Claimant / Conse	rvator			A. IDEN	TIFYIN	G INFO	RMATIC	DN				
0043 0255 0044 0045	vator											
Mailing Address 0046 0047						O048				State 0049	Zip Cod 0050	
EMDI OVED	lame 0018				NSURER/ SELF-INSURER 007							
Address 0168 0169		CLAIMS	OFFICE	Name 0188								
0100 0100						SBWC ID	y Table		Insurer/S 0015	Gelf-Insurer	File #	
						Mailing Addr						
City 0165			State 0170	Zip Code 0167		City 0012				State 0013	Zip Coc 0014	de
Employer E-mail			Phone N 0159	lumber		Claims E-mail Phone Number From Party table From Party table					able	
				В.	DEAT	H BENE	FITS #	0082>1 0097=R	=2,3,4,6,9	& N=1,2 (Or 3	
☐ 1. Benefits will be paid at the rate of \$												
Payable from 0088 . The date of the first check is 0192 , the amount is \$ 0186 ,												
And this do							15 IF 0216=	310 The date o	f death wa	as <u>0057</u>		
*File Form WC 2. Benefits will be			eekly bene	efit is less tr	ian the max	because:						
the state of the s	•	N. C.										
) ENITO					
						DEPENI I sheets if						
NAME				ADDRESS					BIR	BIRTHDATE		RELATIONSHIP
				η ΡΔ	RTIAI	DEPEN	DENTS					
		Complete or	ly when					tional sheets	if requi	red)		
NAME				ADDRESS			PHON	E NUMBER	BIR	THDATE		RELATIONSHIP
E. NO DEPEND	ENTS	(Atta	ch check	and mail	to the Sta	ate Board	of Worker	rs' Compens	ation) [OON'T POP	ULATE SE	C B IF 0082>1 AND 0097
This form must be fil												insel of record.
					7.07.0							
Type or Print Name 0140					Signature 0140						Fil	te le Date
E-mail 0138								Phone Number	r			



NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

□ COMMENCE SUSPEND

Board Claim No.	Employe 0043 025	ee Last Name 255	3		Emple 0044	nployee First Name 044				45	Date of	lnjury
No. of Contract			—	A IDEN	TIFYIN	ING INFORMATION						
Name of Claimant / Conser	rvator			A. IDERI	111 1111	G IIVI CI	WIFTIE	/N				
0043 0255 0044 0045 Mailing Address						City				State	Zip Cod	lo.
0046 0047						0048				0049	0050	е
EMPLOYER 0	Name 0018					INSURER/ Name SELF-INSURER 007						
Address 0168 0169						CLAIMS	OFFICE	Name 0188				
0100 0105					SBWC ID	h. Table		Insurer/S	Self-Insurer	File#		
					From Part Mailing Addre	5		0015				
0010 +0011 (IA)												
0165	_		State 0170	Zip Code 0167		O012	_			State 0013	Zip Cod 0014	е
Employer E-mail			Phone No.	lumber		Claims E-ma	Party table				Number n Party ta	able
^			7.000		DEAT		•					
□1 - 6 311						H BENE						
1. Benefits will be Payable from												
Payable from The date of the first check is, the amount is \$, And this does not / does include a% penalty in the amount of \$, The date of death was												
	And this □ does not / □ does include a % penalty in the amount of \$ The date of death was *File Form WC-6, Wage Statement, if weekly benefit is less than the maximum											
☐ 2. Benefits will be	at the month of the state of th					because:	SD=Directed b	y Jurisdiction+ 02 on Change +0233	233.			
								hausted +0233				
						SEDENI	SENITO					
						DEPEND al sheets if i						
NAME				ADDRESS				E NUMBER	BIR	RTHDATE		RELATIONSHIP
									1			
	$\overline{}$								+			
									<u> </u>			
		- 14				DEPENI			., ,			
NAME	- 	complete on	ly when t					tional sheets E NUMBER				RELATIONSHIP
111	-+			ADDITECT			111-	E NOME		(Iner		NELTHIO
ļ	\rightarrow								+			
E. NO DEPEND	DENTS	□ (Atta	ch check	and mail t	o the Str	ate Board	of Worker	s' Compens	ation)			
								•		*/->	1 11	1.7
This form must be file	ed with the	State Board or	Workers	Compensation	. A copy o	of both sides	of this form r	nas been sent to	the clain	nant(s) ar	nd all cou	nsel of record.
Type or Print Name					Signature 0140						Dat File	te e Date
E-mail 0138								Phone Number	Г			

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).

NOTICE OF PAYMENT / SUSPENSION OF DEATH BENEFITS

WC-3



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO CONTROVERT

Board Claim No. 0005		Employee Last Name 0043 +0255(IA)	Employee 0044	e First Name		M.I.		Date of Injury 0031			
-		0043 10233(IA)	0044			0045					
		A. IDENTIFYI	NG INF	ORMATION							
EMPLOYEE	Mailing Address 0046 +0047 (IA)		City 0048		State 0049	Zip (
Employee E-mail Ad	idress	*		Phone Number							
NA	Name			0051			Phone N	Number			
EMPLOYER	0018						0159				
Mailing Address 0168 +0169(IA)										
City 0165	,				State 017	10.00	Zip Cod 0167	le			
Employer E-mail Address NA											
INSURER/ SELF-INSURER 007 Insurer/Self-Insurer File # 0015											
CLAIMS OFFICE	Name 0188				Claims Off	ice E-mail Party Tab	le				
SBWC ID Mailing Address From Party table Mailing Address 0010 +0011(IA)											
O012	е										
B. CONTROVERT TYPES											
grounds:	notice, pursuant to	O.C.G.A. §34-9-221, that the right to com	npensation	in this claim is being o	controver	ted on the	followi	ng specific			
		O.C.G.A. §34-9-200 and Board Rule 205 following specific reasons:	5(b), that th	e compensability of th	ne followi	ng medica	al treatn	nent / test is			
☐ 3. If only p	art of the claim is k	peing controverted, state the specific part	of the clair	m and the reason(s) it	is being	controver	ted:				
9		C. CERTIFIC	ATE O	FSERVICE							
This is to certify that a copy of both sides of this notice has been sent to the employee / claimant(s), all counsel of record and any other person with a financial interest, as listed below: Filed in EDI											
Type or Print Name		Signature						Date			
0140		0140						0003			
Phone Number 0137		E-mail Add 0138	dress								
		State Board of Workers' Compensation. the claim including, but not limited to the						employee and any other			
		عرب من المناسب	,, J.,		\-/ =		-				

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-666-3818 OR 1-800-533-0682 OR VISIT https://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).

1 OF 2



NOTICE TO CONTROVERT

Board Claim No.		Employee Last Name	ame Employee First Name		M.I.	Date of Injury			
0005		0043 +0255(IA)	0044		0045	0031			
A. IDENTIFYING INFORMATION									
	Mailing Address	A. IDEN		MATION	State	7in Code			
EMPLOYEE	0046 +0047 (I	A)	City 0048		0049	Zip Code 0050			
Employee E-mail Ad	ddress		Phone 005	Number 1	!	-			
15700	Name			Phone Number					
EMPLOYER	0018			0159					
Mailing Address 0168 +0169(IA	\ \								
City)		State Zip Code						
0165 Employer E-mail Ad	ddress			0	170	0167			
NA									
INSURER/	Name 007			Aresero perior	Self-Insurer File	#			
SELF-INSURE	R				0015 Claims Office E-mail				
CLAIMS OFFICE	Name 0188				onice E-mail n Party Tab	le			
SBWC ID From Party tab	Mailing Address								
O012	•				ate 013	Zip Code 0014			
		В. С	ONTROVERT T	/PES					
grounds:	notice, pursuant to	o O.C.G.A. §34-9-221, that the rig	nt to compensation in thi	s claim is being controv	erted on the	following specific			
2. This is r	notice, pursuant t	o O.C.G.A. §34-9-200 and Board	Rule 205(b), that the cor	mpensability of the follo	wing medica	al treatment / test is			
		e following specific reasons:							
PD 029 OR	4=D>0294+019	7							
3. If only p	art of the claim is	being controverted, state the spe	cific part of the claim an	d the reason(s) it is beir	ng controver	ted:			
PD 020)4=E> 0294 +01	07							
15020	0204 101								
C. CERTIFICATE OF SERVICE									
		y of both sides of this notice has	AND DESCRIPTION AND ADDRESS OF THE PARTY OF		unsel of rec	ord and any other person with			
a financial	l interest, as liste	d below:							
Filed in EDI									
Type or Print Name			Signature			Date			
0140			0140			0003			
Phone Number 0137			E-mail Address 0138			•			
This form must	be filed with the	State Board of Workers' Compe	nsation. A copy of both	n sides of this form mu	st be given	to the employee and any other			
person with a fi	nanciai interest i	n the claim including, but not limit	ed to the employer, med	iicai care provider(s) ar	iu attorney(s	5).			



CASE PROGRESS REPORT (File per Board Rule 61(b)(5))

			☐ Initial			□ Final □ F	Reopen	ed
Board Claim No.		oyee Last Name 3 +0255(IA)		Emp 004	oloyee First Name		M.I. 0045	Date of Iniury
			A. ID	ENTIFYIN	IG INFORMATI	ON		
EMDI OVED	lame 0018				r/Self Insurer File Number			Date of Final Weekly Payment NA
		B. IN	DEMNITY P	AYMENT	S (enter actual	l amounts paid)		
			ATE		WEEKS	DAYS	1 5	TOTAL PAYMENTS
☐ (a) Temporary Total	ıl.							
☐ (b) Temporary Parti	ial							
☐ (c) Permanent Parti	ial						\perp	
☐ (d) Death	\perp						\perp	
☐ (e) Stipulation/Settle	ement							
☐ (f) Advances								
			C TO	TAL DAY	MENTS TO DA	TE	\neg	
		1 Total Inde		IALFAI	MENTS TO DA	I E	_	
		* ***		+				
		3 Hospital					_	
		4 Pharmacy 5 Physical T	8					
		5 Physical T	150/50				_	
		6 Chiropract	10041 OS				_	
		7 Other (Me	edical) ation / Vocational					
		o (excluding	g all of the above)	<u>A</u>				
			ment Penalties					
		10 Assessed	Attorney's Fees					
		11 Burial						
		Totals						
			D.	PECOVE	RY PAYMENTS	<u> </u>		
Recove	rv code	: 🗆 for Sub	brogation	20 A SO A SOA	Y.		□ Othe	er
Remarks	OVER CL	951	<u> </u>	<u> </u>	Torpay	10. 5		<u> </u>
		100 Annie (100 pers) - 1.10		AP DAY SENTENDED AND SERVICE	TFICATION			
I certify that t	the total pa	ayments are as co	prrect as the ava	ailable inform	nation indicates.			Date
0188			1	0188				File Date
Address 0010 +0011 (IA)						E-mail From Party Table		SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS
City			State	Zip Code		Phone Number		
0012 Insurer/Self Insurer Name			0013	0014	Claims Office Name	From Party table		
0007					0188			

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).

WC-4 REVISION 7/2021 **4** CASE PROGRESS REPORT



WC-4 CASE PROGRESS REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CASE PROGRESS REPORT (File per Board Rule 61(b)(5))

	Chec	k Only One:	□ Initial		pplemental	□ Final □	Reopen	ed
Board Claim No.	300000 1 To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				Employee First Name M.I. 0044 004			Date of Iniury 0031
			A. IDE	NTIFYIN	IG INFORMATIO	ON		
EMPLOYER	Name 0018				/Self Insurer File Number	SBWC ID# (five digit	53	Date of Final Weekly Payment NA
		B. II	JDEMNITY PA	YMENT	S (enter actual a	amounts paid)		
			RATE		WEEKS	DAYS		TOTAL PAYMENTS
☐ (a) Temporary Tot	otal							
☐ (b) Temporary Pa	ırtial							
☐ (c) Permanent Pa	urtial							
☐ (d) Death								
e) Stipulation/Set)293=SF OR SP				0086 OR 021		The same of the sa
f) Advances	0	0293=AD					00	086 OR 0218
			СТОТ	ΛΙ ΡΔΥΙ	MENTS TO DAT	re	\neg	
		1 Total Ind	120:265 BK 1005/19000	AL FAIL	/IENTO TO DA.	<u> </u>	\dashv	
		2 Physician					-	
		2 Physician 3 Hospital					\dashv	
		4 Pharmac		-			\dashv	
			l Therapy				\dashv	
		6 Chiropra	III 1882				\dashv	
		7 Other (M	Sta (602) 6s				\dashv	
		g Rehabilit	itation / Vocational				\dashv	
		(excludin	ng all of the above) yment Penalties				\dashv	
		*	ed Attorney's Fees				\dashv	
		11 Burial	Training C.				\dashv	
		Totals					\dashv	
		1						
			200		RY PAYMENTS			
	ery code	e: 🗆 for Sı	ubrogation [☐ for Ov	verpayment	□ for SITF	□ Othe	er
Remarks SETTL	_EMENT O	OR ADVANCE						
				F CERT	IFICATION			
☐ I certify that	at the total r	navments are as	correct as the availa		Mr. Decrees were accommoded			
Type or Print Name		aymon		Signature	ducii		,	Date
0188 Address				0188	T F	E-mail		File Date
0010 +0011 (IA))				500	mail From Party Table	,	
City 0012			and the second second	Zip Code	Pl	Phone Number From Party table		
Insurer/Self Insurer Nam	ทอ		0013	0014	Claims Office Name	From Farty takes	<u> </u>	
0007					0188			



	Chec	k Only One:		Supplemental	□ Final □		ned	
Board Claim No.				Employee First Name		M.I. 0045	Date of Iniurv	
			A. IDE	NTIFYING INFORMA	TION			
EMPLOYER Name 0018			Insurer /Self Insurer File Numb 0015	SBWC ID# (five di	56 L	Date of Final Weekly Payment NA		
		B. IND	EMNITY PA	AYMENTS (enter actu	al amounts paid	l)		
		RAT	Έ	WEEKS DAYS			TOTAL PAYMENTS	
☐ (a) Temporary Total		0085=050/250/0134	1	0090 0091			0086	
(b) Temporary Partia	al	0085=070, static "	VARIES'	0090 0091			0086	
(c) Permanent Partia	al	0085=030/0134		0090	0091		0086	
☐ (d) Death	1	0085=010/0134		0090	0091)	0086	
(e) Stipulation/Settler	ment	0085=500/ 0293=SF	OR SP				0086 OR 0218	
☐ (f) Advances	1	0085 = 500/ 0293=AI	0				0086 OR 0218	
				AL DAYMENTO TO D	A T.F.	1		
		Allers I will be of the local and an allers of the first	Service Contacts	AL PAYMENTS TO D	0.000			
		1 Total Indem	nity	3 TO STATE OF THE	0086 + 0218= total			
		2 Physician		0216/350		-		
		3 Hospital		0216/360 0216/450				
		4 Pharmacy		1.000 F14F NO-34 (NO-34				
		5 Physical Therapy		0216/460				
		6 Chiropractic		0216/465 0216/370+455+ 470+ 475=Total				
		7 Other (Medi	cal) on / ∀ocational					
			ll of the above)	0216/400+380+390=Total				
		9 Late Payme	nt Penalties	0216/310				
		10 Assessed A	ttorney's Fees	0216/490			_	
		11 Burial		0216/300				
		Totals		Total Section C				
			D. F	RECOVERY PAYMEN	TS			
Recover	y code	e: 🗆 for Subr	ogation	□ for Overpayment	□ for SITF	□ Oth	er	
DN0226=820 DN0266=830	0= Check "S 0,840,880,89	k "Other" Payment from Prev Subrogation" - Description - A 0 = Check "Overpayment" - D For SITF" - Description - Amo	mount escription - Amount	The state of the s				
				- A-DTI-LA-TION				
The said all and all				E. CERTIFICATION				
I certify that the Type or Print Name	ie totai p	payments are as con	ect as the ava	ilable information indicates. Signature			Date	
0188				0188			File Date	
Address 0010 +0011 (IA)					E-mail From Party Table			
City State 0012 0013			Zip Code 0014	Phone Number From Party table				
Insurer/Self Insurer Name			0010	Claims Office Nam	Programme Chronic Street			

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0188

REVISION 7/2021 WC-4

0007



	Chr		GRESS RI □ Initial		(File per Boa oplemental		(b)(5)) Reopen	ad	
Board Claim No.	Er	mployee Last Name		-	byee First Name	Fillai u	M.I. 0045	Date of Iniury	
			Δ IDE	ENTIFYING	3 INFORMATIO				
EMPLOYER	Name				Self Insurer File Number	SBWC ID# (five dig		Date of Final Weekly Payment	
		B. IND	EMNITY P	AYMENTS	(enter actual a	amounts paid)		
8		RA*			WEEKS	DAYS		TOTAL PAYMENTS	
(a) Temporary To	Total	0085=050/250/0134		+	0090	0091		0086	
☐ (b) Temporary P		0085=070, static			0090	0091		0086	
(c) Permanent P		0085=030/0134			0090	0091		0086	
(d) Death		0085=010/0134			0090	0091		0086	
(e) Stipulation/Se	ettlement	0085=500/ 0293=S	F OR SP				0	0086 OR 0218	
(f) Advances	STORE SAMPLE SAMP	0085=500/ 0293=A	D				0	086 OR 0218	
				•					
			C. TOT	TAL PAYM	IENTS TO DAT	Έ			
		1 Total Indem	nnity	300	86 + 0218= total				
		2 Physician		021	16/350				
		3 Hospital		021	0216/360				
		4 Pharmacy		0210	6/450				
		5 Physical Th	nerapy	021	6/460				
		6 Chiropractio	С	0210	6/465				
		7 Other (Med	lical)	0216/	/370+455+ 470+ 47	75=Total			
			ion / Vocational all of the above)	0216	3/400+380+390=To	otal			
			ent Penalties	0216	i/310				
		10 Assessed A	Attorney's Fees	0216	6/490				
		11 Burial		0216/					
		Totals		100000	al Section C				
		11 11 11 11 11 11 11 11 11 11 11 11 11							
			0.00		Y PAYMENTS		Section 1		
	very co	and the second of the second o	progation	terior contract movement	erpayment [☐ for SITF	☐ Othe	er	
DN0226 DN026	26=820= Check 66=830,840,880	Check "Other" Payment from Pre k "Subrogation" - Description - A 0,890 = Check "Overpayment" - I ck "For SITF" - Description - Amo	Amount Description - Amount		nt				
				E. CERTIF	FICATION				
I certify th	at the tota	al payments are as cor			AU DECEMBER DE LA COMPANSIONE				
Type or Print Name	4.	" P=J	103. 22	Signature				Date	
0188				0188		-15050 qt		File Date	
Address 0010 +0011 (IA	4)					-mail From Party Table	e		
City	*		State	Zip Code	Ph	hone Number			
0012			0013	0014		From Party table	В		
Insurer/Self Insurer Nar 0007	me				Claims Office Name 0188				

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).

REVISION 7/2021