WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

FROI 00/ AU(M)

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male 0053 ☐ Female	Birthdate 0052	Phone Number 0051	Employee E-mail X
Mailing Address 0046+0047(IA)		City 0048	State 0049	Zip Code 0050
EMPLOYER	Name 0018	NAICS Code 0025	Nature of Business (Trade, Transport, Mfg.,etc.) Map to NAICS type description	
Mailing Address 0168+0169(IA)		Phone Number 0159	Employer FEIN 0016	
City 0165	State 0170	Zip Code 0167	Employer E-mail X	
INSURER / SELF-INSURER	Name 0007	Insurer/Self-Insurer FEIN 0006	Insurer/ Self-Insurer File # 0015	
CLAIMS OFFICE	Name 0188	Claims Office FEIN # 0187	Claims Office Phone From Party Table	Claims Office E-mail From Party Table
SBWC ID# (five digit no.) From Party Table	Mailing Address 0010+0011(IA)	City 0012	State 0013	Zip Code 0014

EMPLOYMENT/WAGE	Date Hired by Employer 0061	Job Classified Code No. 0059	Number of Days Worked Per Week 0064	Wage rate at time of Injury or Disease: 0062 ☐ per Hour =07 ☐ per Day =06 ☐ per Week =01 ☐ per Month =04 0063
Insurer Type Code From party Table ☐I – Insurer ☐S-Self-insurer ☐Group Fund		List Normally Scheduled Days Off 0204=S=Sat, Sun 0204=F,V= Varies		

INJURY/ILLNESS & MEDICAL	Time of Injury 0032 ☐ am ☐ pm	County of Injury 0188	Date Employer had knowledge of Injury 0040	Enter First Date Employee Failed to Work a Full Day 0056
Did Employee Receive Full Pay on Date of Injury? 0066 ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? 0249 L OR X ☐ Yes E ☐ No	Type of Injury/Illness 0035	Body Part Affected 0036	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address) X	Initial Treatment Given: 0039 ☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	Hospital / Treating Facility (Name and Address) X	If Returned to Work, Give Date: X Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

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 CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☑ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
0188	0188	File Date
Phone Number From party table	E-mail From Party Table	

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 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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EMPLOYER	Name 0018	NAICS Code 0025	Nature of Business (Trade, Transport, Mfg.,etc.) Map to NAICS type description	
Mailing Address 0168+0169(IA)		Phone Number 0159	Employer FEIN 0016	
City 0165	State 0170	Zip Code 0167	Employer E-mail X	
INSURER / SELF-INSURER	Name 0007	Insurer/Self-Insurer FEIN 0006	Insurer/ Self-Insurer File # 0015	
CLAIMS OFFICE	Name 0188	Claims Office FEIN # 0187	Claims Office Phone From Party Table	Claims Office E-mail From Party Table
SBWC ID# (five digit no.) From Party Table	Mailing Address 0010+0011(IA)	City 0012	State 0013	Zip Code 0014
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Did Employee Receive Full Pay on Date of Injury? 0066 ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? 0249 L OR X ☐ Yes E ☐ No	Type of Injury/Illness 0035	Body Part Affected 0036	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address) X	Initial Treatment Given: 0039 ☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	Hospital / Treating Facility (Name and Address) X	If Returned to Work, Give Date: X Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057	

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

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☑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

0294+0197

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
0140	0140	File Date
Phone Number 0137	E-mail 0138	

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FROI 00/
AU/ SROI 04

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EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male 0053 ☐ Female	Birthdate: 0052	Phone Number: 0051	Employee E-mail: X
Mailing Address: 0046+0047(IA)		City: 0048	State: 0049	Zip Code: 0050
EMPLOYER	Name: 0018	NAICS Code: 0025	Nature of Business (Trade, Transport, Mfg.,etc.): Map to NAICS type description	
Mailing Address: 0168+0169(IA)		Phone Number: 0159		Employer FEIN: 0016
City: 0165	State: 0170	Zip Code: 0167	Employer E-mail: X	
INSURER / SELF-INSURER	Name: 0007	Insurer/Self-Insurer FEIN: 0006		Insurer/ Self-Insurer File #: 0015
CLAIMS OFFICE	Name: 0188	Claims Office FEIN #: 0187	Claims Office Phone: From Party Table	Claims Office E-mail: From Party Table
SBWC ID# (five digit no.): From Party Table	Mailing Address: 0010+0011(IA)	City: 0012	State: 0013	Zip Code: 0014

EMPLOYMENT/WAGE	Date Hired by Employer: 0061	Job Classified Code No.: 0059	Number of Days Worked Per Week: 0064	Wage rate at time of Injury or Disease: 0062 ☐ per Hour =07 ☐ per Day =06 ☐ per Week =01 ☐ per Month =04 0063
Insurer Type Code From party Table ☐I – Insurer ☐S-Self-insurer ☐Group Fund		List Normally Scheduled Days Off 0204=S=Sat, Sun 0204=F,V= Varies		

INJURY/ILLNESS & MEDICAL	Time of Injury 0032 ☐ am ☐ pm	County of Injury: 0188	Date Employer had knowledge of Injury: 0040	Enter First Date Employee Failed to Work a Full Day: 0056
Did Employee Receive Full Pay on Date of Injury? 0066 ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? 0249 L OR X ☐ Yes E ☐ No	Type of Injury/Illness: 0035	Body Part Affected: 0036	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address): X	Initial Treatment Given: 0039 ☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	Hospital / Treating Facility (Name and Address): X	If Returned to Work, Give Date: X Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability: _____

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

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 CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:
0198+0197

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
0140	0140	File Date
Phone Number: 0137	E-mail: 0138	

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WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

FROI 00+ EP

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE

☐ Male 0053 ☐ Female	Birthdate	Phone Number	Employee E-mail
	0052	0051	X

Mailing Address	City	State	Zip Code
0046+0047(IA)	0048	0049	0050

EMPLOYER

Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
0018	0025	Map to NAICS type description

Mailing Address	Phone Number	Employer FEIN
0168+0169(IA)	0159	0016

City	State	Zip Code	Employer E-mail
0165	0170	0167	X

INSURER / SELF-INSURER

Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
0007	0006	0015

CLAIMS OFFICE

Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
0188	0187	From Party Table	From Party Table

SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code
From Party Table	0010+0011(IA)	0012	0013	0014

EMPLOYMENT/WAGE

Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease:
0061	0059	0064	0062 ☐ per Hour =07 ☐ per Day =06 ☐ per Week =01 ☐ per Month =04 0063

Insurer Type Code (From party Table)	List Normally Scheduled Days Off
☐I – Insurer ☐S-Self-insurer ☐Group Fund	0204=S=Sat, Sun 0204=F,V= Varies

INJURY/ILLNESS & MEDICAL

Time of Injury	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
0032 ☐ am ☐ pm	0188	0040	0056

Did Employee Receive Full Pay on Date of Injury? 0066	Did Injury/Illness Occur on Employer's premises? 0249 L OR X	Type of Injury/Illness	Body Part Affected
☐ Yes ☐ No	☐ Yes E ☐ No	0035	0036

How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address)	Initial Treatment Given: 0039	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: X
X	☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	X	Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☑ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only	Average Weekly Wage: $	Weekly benefit: $	Date of disability:
☐ Yes ☐ No	0286	0134	0056

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: 0088 Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM 0088 FOR:

☑ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

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 CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
0140	0140	File Date
Phone Number	**E-mail**	
0137	0138	

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FROI 00+IP

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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

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INSURER / SELF-INSURER	Name 0007	Insurer/Self-Insurer FEIN 0006	Insurer/ Self-Insurer File # 0015	
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Did Employee Receive Full Pay on Date of Injury? 0066 ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? 0249 L OR X ☐ Yes E ☐ No	Type of Injury/Illness 0035	Body Part Affected 0036	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address) X	Initial Treatment Given: 0039 ☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	Hospital / Treating Facility (Name and Address) X	If Returned to Work, Give Date: X Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☑ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ 0286 Weekly benefit: $ 0134 Date of disability: 0144 Or 0056

Date of first Payment: 0192 Compensation paid: $ 0086 or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM 0088 FOR:

Only for 030

☐ 050 Temporary total disability ☐ 070 Temporary partial disability ☐ 030 Permanent partial disability of 0084 % to 0083 for 0090 weeks.

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.

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FROI 04

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0198+0197

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FROI AU/AP

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EMPLOYER	Name 0018	NAICS Code 0025	Nature of Business (Trade, Transport, Mfg.,etc.) Map to NAICS type description	
Mailing Address 0168+0169(IA)		Phone Number 0159	Employer FEIN 0016	
City 0165	State 0170	Zip Code 0167	Employer E-mail X	
INSURER / SELF-INSURER	Name 0007	Insurer/Self-Insurer FEIN 0006	Insurer/ Self-Insurer File # 0015	
CLAIMS OFFICE	Name 0188	Claims Office FEIN # 0187	Claims Office Phone From Party Table	Claims Office E-mail From Party Table
SBWC ID# (five digit no.) From Party Table	Mailing Address 0010+0011(IA)	City 0012	State 0013	Zip Code 0014

EMPLOYMENT/WAGE	Date Hired by Employer 0061	Job Classified Code No. 0059	Number of Days Worked Per Week 0064	Wage rate at time of Injury or Disease: 0062 ☐ per Hour =07 ☐ per Day =06 ☐ per Week =01 ☐ per Month =04 0063
Insurer Type Code From party Table ☐I – Insurer ☐S-Self-insurer ☐Group Fund	List Normally Scheduled Days Off 0204=S=Sat, Sun 0204=F,V= Varies			

INJURY/ILLNESS & MEDICAL	Time of Injury 0032 ☐ am ☐ pm	County of Injury 0188	Date Employer had knowledge of Injury 0040	Enter First Date Employee Failed to Work a Full Day 0056
Did Employee Receive Full Pay on Date of Injury? 0066 ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? 0249 L OR X ☐ Yes E ☐ No	Type of Injury/Illness 0035	Body Part Affected 0036	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address) X	Initial Treatment Given: 0039 ☐ None 0 ☐ Minor: By Employer 1 ☐ Minor: Clinical/Hospital 2 ☐ Emergency Room 3 ☐ Hospitalized > 24hrs 4	Hospital / Treating Facility (Name and Address) X	If Returned to Work, Give Date: X Returned at what wage X per Week If Fatal, Enter Complete Date of Death 0057

Report Prepared By (Print or Type)	Telephone Number	Date of Report
0160	0159	0041

☑ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ 0286 Weekly benefit: $ 0134 Date of disability: 0144 Or 0056

Date of first Payment: 0192 Compensation paid: $ 0086 or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM 0088 FOR:

Only for 030

☐ Temporary total disability 050 ☐ Temporary partial disability 070 ☐ Permanent partial disability 030 of 0084 % to 0083 for 0090 weeks.

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 CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
0140	0140	File Date
Phone Number 0137	E-mail 0139	

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-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

AP

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☑ RE-COMMENCE ☐ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170	Zip Code 0167	
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014	

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of 0134 *per week based on an average weekly wage of $ 00286

payable from 0088 / _____ / _____ for: if BTC=070, static map "VARIES"

☐ Temporary Total Disability BTC=050/250

☐ Temporary Partial Disability BTC=070

☐ Permanent Partial Disability of 0084 % to 0083 (Part of Body) to be paid for 0090 weeks (**medical report attached**). ONLY FOR BTC=030

Date of Disability 0056

The date of the first check is, 0192(BTC=050,070,030) , the amount is $ 0086(BTC=050,070,030) , or date salary was paid 0088 (BTC=250) and this:

☐ Does not include a penalty if 0216 <>310

☐ Does include a 15 % penalty in the amount of $ if 0216 has 310=0215 .

*File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

C. SUSPENSION OF BENEFITS

Benefits will be suspended on _____ because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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:

Insurer/Self-Insurer Type or Print Name 0140	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 both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

CB

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☑ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170	Zip Code 0167	
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014	

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of 0134 or _____ *per week based on an average weekly wage of $ 00286

payable from 0088 / _____ / _____ for: if BTC=070, static map "VARIES"

☐ Temporary Total Disability BTC=050/250

☐ Temporary Partial Disability BTC=070

☐ Permanent Partial Disability of 0084 % to 0083 (Part of Body) to be paid for 0090 weeks (**medical report attached**). ONLY FOR BTC=030

Date of Disability 0056

The date of the first check is, 0192(BTC=050,070,030) , the amount is $ 0086(BTC=050,070,030) , or date salary was paid 0088 (BTC=250) and this:

☐ Does not include a penalty if 0216 <>310

☐ Does include a 15 % penalty in the amount of $ if 0216 has 310=0215 .

*File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

C. SUSPENSION OF BENEFITS

Benefits will be suspended on 0089(Active benefits that was previous reported) because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: Change In Benefit + 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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

IP/EP

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☑ INITIAL PAYMENT ☐ RE-COMMENCE ☐ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)	
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170 / Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of 0134 *per week based on an average weekly wage of $ 00286

payable from 0088 / _____ / _____ for: if BTC=070, static map "VARIES"

☐ Temporary Total Disability BTC=050/250

☐ Temporary Partial Disability BTC=070

☐ Permanent Partial Disability of 0084 % to 0083 (Part of Body) to be paid for 0090 weeks (**medical report attached**). ONLY FOR BTC=030

Date of Disability 0056

The date of the first check is, 0192(BTC=050,070,030) , the amount is $ 0086(BTC=050,070,030) , or date salary was paid 0088 (BTC=250) and this:

☐ Does not include a penalty if 0216 <>310

☐ Does include a 15 % penalty in the amount of $ if 0216 has 310=0215 .

*File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

C. SUSPENSION OF BENEFITS

Benefits will be suspended on _____ because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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:

Insurer/Self-Insurer Type or Print Name 0140	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 both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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RB/ER

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☑ RE-COMMENCE ☐ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170	Zip Code 0167	
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014	

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of 0134 *per week based on an average weekly wage of $ 00286

payable from 0088 / _____ / _____ for: if BTC=070, static map "VARIES"

☐ Temporary Total Disability BTC=050/250

☐ Temporary Partial Disability BTC=070

☐ Permanent Partial Disability of 0084 % to 0083 (Part of Body) to be paid for 0090 weeks (**medical report attached**). ONLY FOR BTC=030

Date of Disability 0056

The date of the first check is, 0192(BTC=050,070,030) , the amount is $ 0086(BTC=050,070,030) , or date salary was paid 0088 (BTC=250) and this:

☐ Does not include a penalty if 0216 <>310

☐ Does include a 15 % penalty in the amount of $ if 0216 has 310=0215 .

*File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

C. SUSPENSION OF BENEFITS

Benefits will be suspended on _____ because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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:

Insurer/Self-Insurer Type or Print Name 0140	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 both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S1

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)			
City 0048	State 0049	Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)		City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on 0189/A & 0224/N-->S1<--0072/ If NA then 0068 without restrictions from the authorized treating physician. OR

☐ 2.) Employee returned to work on 0189/A & 0224/Y-->S1<--0072/ If NA then 0068 with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: If 0189/R then "Release to RTW") = "DATE" < date from transaction 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**	
0137	0138	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S1

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)			
City 0048	State 0049	Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)		City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on 0189/A & 0224/N-->S1<--0072/ If NA then 0068 without restrictions from the authorized treating physician. OR

☐ 2.) Employee returned to work on 0189/A & 0224/Y-->S1<--0072/ If NA then 0068 with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: If 0189/R then "Release to RTW") = "DATE" < date from transaction in 0072 or 0068> + < Narrative-0233 (If Available)

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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

S2

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170	Zip Code 0167	
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014	

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: "Medical Non-Compliance"+ "RTW DATE" <date from 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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S3

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170	Zip Code 0167	
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014	

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: Administrative Non- Compliance+RTW DATE <date from 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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S4

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)			
City 0048	State 0049 / Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)	City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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 Death +233

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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S5

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)	
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170 / Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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 Incarceration +233

Insurer/Self-Insurer Type or Print Name	Signature	Date
0140	0140	File Date
Phone Number	**E-mail**	
0137	0138	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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S6

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE		EMPLOYER	Name 0018
Mailing Address 0046+0047(IA)		Mailing Address 0168+0169(IA)	
City 0048	State 0049 / Zip Code 0050	City 0165	State 0170 / Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)	City 0012	State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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 Print Name	Signature	Date
0140	0140	File Date
Phone Number	**E-mail**	
0137	0138	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

S7

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)			
City 0048	State 0049	Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)		City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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. S7(050) /Or (250)

☐ 8.) The entire permanent partial disability benefit has been paid. S7(030)/ Or

☐ 9.) The maximum of temporary partial disability payments has been paid. S7(070)

☐ 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: 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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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

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WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

S8

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)			
City 0048	State 0049	Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)		City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: Jurisdiction Change +233

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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

SD

WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☑ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043+0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE			EMPLOYER	Name 0018		
Mailing Address 0046+0047(IA)			Mailing Address 0168+0169(IA)			
City 0048	State 0049	Zip Code 0050	City 0165		State 0170	Zip Code 0167
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# From Party table	Mailing Address 0010+00119(IA)		City 0012		State 0013	Zip Code 0014

B. INCOME 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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

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. SUSPENSION OF BENEFITS

Benefits will be suspended on 0193 because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced 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: **Directed by Jurisdiction (SD) +233**

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. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

IP/RB 0085=010

WC-2a NOTICE OF PAYMENT / SUSPENSION OF DEATH BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

☑ COMMENCE ☐ SUSPEND

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
005	0043 0255	0044	0045	0031

A. IDENTIFYING INFORMATION

Name of Claimant / Conservator: 0043 0255 0044 0045

Mailing Address	City	State	Zip Code
0046 0047	0048	0049	0050

EMPLOYER	Name	INSURER/ SELF-INSURER	Name
	0018		007
Address		CLAIMS OFFICE	Name: 0188
0168 0169		SBWC ID: From Party Table	Insurer/Self-Insurer File #: 0015
		Mailing Address: 0010 +0011 (IA)	

City	State	Zip Code	City	State	Zip Code
0165	0170	0167	0012	0013	0014

Employer E-mail	Phone Number	Claims E-mail	Phone Number
x	0159	From Party table	From Party table

B. DEATH BENEFITS IF 0082>1 0097=R=2,3,4,6,9 & N=1,2 Or 3

☐ 1. Benefits will be paid at the rate of $ 0134 *per week based on an average weekly wage of $ 0286 ,

Payable from 0088 . The date of the first check is 0192 , the amount is $ 0186 ,

And this ☐ does not / ☐ does include a 20 % penalty in the amount of $ 0215 IF 0216=310 The date of death was 0057 .

***File Form WC-6, Wage Statement, if weekly benefit is less than the maximum**

☐ 2. Benefits will be suspended on _____ because:

C. TOTAL DEPENDENTS

(Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

D. PARTIAL DEPENDENTS

(Complete only when there are no total dependents. Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

E. NO DEPENDENTS

☐ (Attach check and mail to the State Board of Workers' Compensation) DON'T POPULATE SEC B IF 0082>1 AND 0097 =R=8 AND N=0

☐ This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

Type or Print Name	Signature	Date
0140	0140	File Date

E-mail	Phone Number
0138	0137

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-2a NOTICE OF PAYMENT / SUSPENSION OF DEATH BENEFITS

S7/S8/SD 0085=010

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

☐ COMMENCE ☑ SUSPEND

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
005	0043 0255	0044	0045	0031

A. IDENTIFYING INFORMATION

Name of Claimant / Conservator: 0043 0255 0044 0045

Mailing Address	City	State	Zip Code
0046 0047	0048	0049	0050

EMPLOYER	Name	INSURER/ SELF-INSURER	Name
	0018		007
Address		CLAIMS OFFICE	Name
0168 0169			0188
		SBWC ID	Insurer/Self-Insurer File #
		From Party Table	0015
		Mailing Address	
		0010 +0011 (IA)	

City	State	Zip Code	City	State	Zip Code
0165	0170	0167	0012	0013	0014

Employer E-mail	Phone Number	Claims E-mail	Phone Number
x	0159	From Party table	From Party table

B. DEATH BENEFITS

☐ 1. Benefits will be paid at the rate of $ _____ *per week based on an average weekly wage of $ _____ ,

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 _____ .

*File Form WC-6, Wage Statement, if weekly benefit is less than the maximum

☐ 2. Benefits will be suspended on 0193 because: SD=Directed by Jurisdiction+ 0233
S8= Jurisdiction Change +0233
S7=Benefit Exhausted +0233

C. TOTAL DEPENDENTS

(Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

D. PARTIAL DEPENDENTS

(Complete only when there are no total dependents. Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

E. NO DEPENDENTS

☐ (Attach check and mail to the State Board of Workers' Compensation)

☐ This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

Type or Print Name	Signature	Date
0140	0140	File Date

E-mail	Phone Number
0138	0137

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).

SROI 04

WC-3 NOTICE TO CONTROVERT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO CONTROVERT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE	Mailing Address: 0046 +0047 (IA)	City: 0048	State: 0049	Zip Code: 0050
Employee E-mail Address: NA		Phone Number: 0051		
EMPLOYER	Name: 0018			Phone Number: 0159
Mailing Address: 0168 +0169(IA)				
City: 0165			State: 0170	Zip Code: 0167
Employer E-mail Address: NA				
INSURER/ SELF-INSURER	Name: 007			Insurer/Self-Insurer File #: 0015
CLAIMS OFFICE	Name: 0188			Claims Office E-mail: From Party Table
SBWC ID: From Party table	Mailing Address: 0010 +0011(IA)			
City: 0012			State: 0013	Zip Code: 0014

B. CONTROVERT TYPES

☐ 1. This is notice, pursuant to O.C.G.A. §34-9-221, that the right to compensation in this claim is being controverted on the following specific grounds:

DN0198 +0197

☐ 2. This is notice, pursuant to O.C.G.A. §34-9-200 and Board Rule 205(b), that the compensability of the following medical treatment / test is being controverted for the following specific reasons:

☐ 3. If only part of the claim is being controverted, state the specific part of the claim and the reason(s) it is being controverted:

C. CERTIFICATE OF SERVICE

☐ 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 Address: 0138	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be given to the employee and any other person with a financial interest in the claim including, but not limited to the employer, medical care provider(s) and attorney(s).

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 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).

WC-3 NOTICE TO CONTROVERT

SROI PD

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO CONTROVERT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

EMPLOYEE	Mailing Address: 0046 +0047 (IA)	City: 0048	State: 0049	Zip Code: 0050
Employee E-mail Address: NA		Phone Number: 0051		
EMPLOYER	Name: 0018			Phone Number: 0159
Mailing Address: 0168 +0169(IA)				
City: 0165			State: 0170	Zip Code: 0167
Employer E-mail Address: NA				
INSURER/ SELF-INSURER	Name: 007			Insurer/Self-Insurer File #: 0015
CLAIMS OFFICE	Name: 0188			Claims Office E-mail: From Party Table
SBWC ID: From Party table	Mailing Address: 0010 +0011(IA)			
City: 0012			State: 0013	Zip Code: 0014

B. CONTROVERT TYPES

☐ 1. This is notice, pursuant to O.C.G.A. §34-9-221, that the right to compensation in this claim is being controverted on the following specific grounds:

PD 0294=A --> 0294 + 0197

OR

☐ 2. This is notice, pursuant to O.C.G.A. §34-9-200 and Board Rule 205(b), that the compensability of the following medical treatment / test is being controverted for the following specific reasons:

PD 0294=D -->0294+0197

OR

☐ 3. If only part of the claim is being controverted, state the specific part of the claim and the reason(s) it is being controverted:

PD 0294=E --> 0294 +0197

C. CERTIFICATE OF SERVICE

☐ 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 Address: 0138	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be given to the employee and any other person with a financial interest in the claim including, but not limited to the employer, medical care provider(s) and attorney(s).

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 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).

AQ

WC-4 CASE PROGRESS REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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

Check Only One: ☐ Initial ☑ Supplemental ☐ Final ☐ Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER	0018	0015	From Party Table	NA

B. INDEMNITY PAYMENTS (enter actual amounts paid)

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
☐ (a) Temporary Total				
☐ (b) Temporary Partial				
☐ (c) Permanent Partial				
☐ (d) Death				
☐ (e) Stipulation/Settlement				
☐ (f) Advances				

C. TOTAL PAYMENTS TO DATE

1	Total Indemnity	
2	Physician	
3	Hospital	
4	Pharmacy	
5	Physical Therapy	
6	Chiropractic	
7	Other (Medical)	
8	Rehabilitation / Vocational (excluding all of the above)	
9	Late Payment Penalties	
10	Assessed Attorney's Fees	
11	Burial	
	Totals	

D. RECOVERY PAYMENTS

Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks

TAKEOVER CLAIM

E. CERTIFICATION

☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature	Date
0188	0188	File Date

Address	E-mail
0010 +0011 (IA)	From Party Table

City	State	Zip Code	Phone Number
0012	0013	0014	From Party table

Insurer/Self Insurer Name	Claims Office Name
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).

PY

WC-4 CASE PROGRESS REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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

Check Only One: ☐ Initial ☑ Supplemental ☐ Final ☐ Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER	0018	0015	From Party Table	NA

B. INDEMNITY PAYMENTS (enter actual amounts paid)

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
☐ (a) Temporary Total				
☐ (b) Temporary Partial				
☐ (c) Permanent Partial				
☐ (d) Death				
☐ (e) Stipulation/Settlement	0293=SF OR SP			0086 OR 0218
☐ (f) Advances	0293=AD			0086 OR 0218

C. TOTAL PAYMENTS TO DATE

1	Total Indemnity	
2	Physician	
3	Hospital	
4	Pharmacy	
5	Physical Therapy	
6	Chiropractic	
7	Other (Medical)	
8	Rehabilitation / Vocational (excluding all of the above)	
9	Late Payment Penalties	
10	Assessed Attorney's Fees	
11	Burial	
	Totals	

D. RECOVERY PAYMENTS

Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks SETTLEMENT OR ADVANCE

E. CERTIFICATION

☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature	Date
0188	0188	File Date

Address	E-mail
0010 +0011 (IA)	From Party Table

City	State	Zip Code	Phone Number
0012	0013	0014	From Party table

Insurer/Self Insurer Name	Claims Office Name
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).

AN

WC-4 CASE PROGRESS REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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

Check Only One: ☐ Initial ☐ Supplemental ☐ Final ☐ Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER	0018	0015	From Party Table	NA

B. INDEMNITY PAYMENTS (enter actual amounts paid)

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
☐ (a) Temporary Total	0085=050/250/0134	0090	0091	0086
☐ (b) Temporary Partial	0085=070, static 'VARIES'	0090	0091	0086
☐ (c) Permanent Partial	0085=030/0134	0090	0091	0086
☐ (d) Death	0085=010/0134	0090	0091	0086
☐ (e) Stipulation/Settlement	0085=500/ 0293=SF OR SP			0086 OR 0218
☐ (f) Advances	0085=500/ 0293=AD			0086 OR 0218

C. TOTAL PAYMENTS TO DATE

1	Total Indemnity	0086 + 0218= total
2	Physician	0216/350
3	Hospital	0216/360
4	Pharmacy	0216/450
5	Physical Therapy	0216/460
6	Chiropractic	0216/465
7	Other (Medical)	0216/370+455+ 470+ 475=Total
8	Rehabilitation / Vocational (excluding all of the above)	0216/400+380+390=Total
9	Late Payment Penalties	0216/310
10	Assessed Attorney's Fees	0216/490
11	Burial	0216/300
	Totals	Total Section C

D. RECOVERY PAYMENTS

Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks
DN0216=430/440= Check "Other" Payment from Previous Claim Admin - Description- Amount
DN0226=820= Check "Subrogation" - Description - Amount
DN0266=830,840,880,890 = Check "Overpayment" - Description - Amount
DN0266 =850 - Check "For SITF" - Description - Amount

E. CERTIFICATION

☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature	Date
0188	0188	File Date

Address	E-mail
0010 +0011 (IA)	From Party Table

City	State	Zip Code	Phone Number
0012	0013	0014	From Party table

Insurer/Self Insurer Name	Claims Office Name
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).

FN

WC-4 CASE PROGRESS REPORT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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

Check Only One: ☐ Initial ☐ Supplemental ☐ Final ☐ Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
0005	0043 +0255(IA)	0044	0045	0031

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER	0018	0015	From Party Table	NA

B. INDEMNITY PAYMENTS (enter actual amounts paid)

	RATE	WEEKS	DAYS	TOTAL PAYMENTS
☐ (a) Temporary Total	0085=050/250/0134	0090	0091	0086
☐ (b) Temporary Partial	0085=070, static 'VARIES'	0090	0091	0086
☐ (c) Permanent Partial	0085=030/0134	0090	0091	0086
☐ (d) Death	0085=010/0134	0090	0091	0086
☐ (e) Stipulation/Settlement	0085=500/ 0293=SF OR SP			0086 OR 0218
☐ (f) Advances	0085=500/ 0293=AD			0086 OR 0218

C. TOTAL PAYMENTS TO DATE

1	Total Indemnity	0086 + 0218= total
2	Physician	0216/350
3	Hospital	0216/360
4	Pharmacy	0216/450
5	Physical Therapy	0216/460
6	Chiropractic	0216/465
7	Other (Medical)	0216/370+455+ 470+ 475=Total
8	Rehabilitation / Vocational (excluding all of the above)	0216/400+380+390=Total
9	Late Payment Penalties	0216/310
10	Assessed Attorney's Fees	0216/490
11	Burial	0216/300
	Totals	Total Section C

D. RECOVERY PAYMENTS

Recovery code: ☐ for Subrogation ☐ for Overpayment ☐ for SITF ☐ Other

Remarks
DN0216=430/440= Check "Other" Payment from Previous Claim Admin - Description- Amount
DN0226=820= Check "Subrogation" - Description - Amount
DN0266=830,840,880,890 = Check "Overpayment" - Description - Amount
DN0266 =850 - Check "For SITF" - Description - Amount

E. CERTIFICATION

☐ I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature	Date
0188	0188	File Date

Address	E-mail
0010 +0011 (IA)	From Party Table

City	State	Zip Code	Phone Number
0012	0013	0014	From Party table

Insurer/Self Insurer Name	Claims Office Name
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

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