GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE & REHABILITATION DIVISION
CATASTROPHIC CERTIFICATION COMMITTEE
270 PEACHTREE STREET, NW
ATLANTA, GA 30303-1299
(404) 656-0849

NOTIFICATION OF INTENT TO APPLY FOR CATASTROPHIC DESIGNATION

Name: _____

Business Address: _____

Fax:

Telephone: _____ _____

Email Address: _____

Home Address: _____

Rehabilitation Supplier# _____

Are you currently and have you been a registered rehabilitation supplier with the Georgia State Board of Workers' Compensation consecutively for the last twenty-four months? _____

Have you been providing case management services to injured workers for the preceeding two years? _____

List all certifications you hold, including expiration dates:

_____

By signing this application, I am verifying that I have read and will abide by the Standards of Practice/Code of Ethics of my specific certifications. I understand that it is my responsibility to meet requirements as outlined in the current O.C.G.A. 34-9-200.1, Rule 200.1 and the Rehabilitation and Managed Care Procedure Manual, which I have read as part of this application. In addition, I realize that changes occur in the rules and the procedures each year and that it is my responsibility to be aware of these changes.

_____ _____

Signature of Applicant **Date**