

STATE BOARD OF WORKERS' COMPENSATION
REHABILITATION REGISTRATION
RENEWAL REHAB SUPPLIER REGISTRATION

**RETURN RENEWAL APPLICATION WITH CHECK OR MONEY ORDER PAYABLE TO THE
STATE BOARD OF WORKERS COMPENSATION FOR \$50.00 TO:**

State Board of Workers Compensation
Managed Care and Rehabilitation Division
270 Peachtree Street, NW, 5th Floor Mailroom
Atlanta, GA 30303-1299
ATTN: Maggie Bessent

ALL APPLICATIONS FOR RENEWAL MUST BE RECEIVED BY NOVEMBER 30th of each year

ANY LATE APPLICATION WILL BE SUBJECT TO A LATE FEE AND/OR PENALTIES. REHABILITATION SUPPLIERS ARE RESPONSIBLE FOR COMPLIANCE WITH ALL RULE CHANGES AND ARE RESPONSIBLE FOR OBTAINING THE RENEWAL APPLICATION.

Any person who fails to renew on or before November 30th, shall be penalized an additional \$25.00. Any person who is delinquent on or after January 1 of each year shall be penalized an additional amount up to \$100.00. Any supplier who has not renewed his/her registration by November 30th of the year following their supplier registration expiration date, shall not be eligible for renewal, and will be required to submit a new application to become a rehabilitation supplier in accordance with Section 200.1

COPIES OF GEORGIA WORKERS' COMPENSATION LAW, RULES AND REGULATIONS
ANNOTATED,
WHICH GOVERN REHABILITATION ACTIVITIES, MAY BE OBTAINED FROM OUR WEB SITE OR
FROM:
LEXIS LAW PUBLISHING
POST OFFICE BOX 7587
CHARLOTTESVILLE, VA 22906-7587
1-800-562-1197

DO YOU WRITE OR SPEAK A FORGEIN LANGUAGE:

YES NO

IF YES, STATE LANGUAGE AND NUMBER OF YEARS:

ARE YOU ABLE TO COMMUNICATE WITH THE DEAF IN SIGN LANGUAGE?

YES NO

HAVE YOU EVER HAD ANY BUSINESS OR PROFESSIONAL LICENSE REVOKED, SUSPENDED OR ANNULLED OR HAD ANY OTHER DISCIPLINARY ACTION TAKEN AGAINST YOU? IF YES,

EXPLAIN

HAVE YOU EVER BEEN REGISTERED UNDER ANY OTHER NAME?

YES NO

IF YES, STATE THE NAME

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE IN GEORGIA:

YES NO

HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OR PLED NOLO CONTENDRE IN A CRIMINAL PROCEEDING?

YES NO

IF YES, EXPLAIN

I HAVE READ, AND AM AWARE OF, O.C.G.A. 34-9-200.1 AND RULE 200.1. ALL OF THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE STATE BOARD OF WORKERS' COMPENSATION TO MAKE ANY INVESTIGATION OF THE FOREGOING INFORMATION. I UNDERSTAND THAT ANY OMISSION OR MISREPRESENTATION MAY RESULT IN REJECTION OR REVOCATION OF REGISTRATION.

SIGNATURE _____ **DATE** _____

If you are a catastrophic supplier and wish to volunteer to serve on a Managed Care & Rehabilitation committee, email Neil Thom at ThomN@sbwc.ga.gov and inform him of same.