GEORGIA STATE BOARD OF WORKERS COMPENSATION
REHABILITATION REGISTRATION APPLICATION
Instructions and Information

CERTIFICATION REQUIREMENTS

A ***REHABILITATION SUPPLIER*** SHALL HOLD ONE OF THE ABOVE CERTIFICATIONS OR LICENSES. Please submit (1) a copy of the certificate, and (2) the application.

CRC – Certified Rehabilitation Counselor
CDMS – Certified Disability Management Specialist
CWAVES – Certified Work Adjustment & Vocational Evaluation Specialist
CRRN – Certified Registered Rehabilitation Nurse Program
LPC – Licensed Professional Counselor
CCM – Certified Case Manager
COHN – Certified Occupational Health Nurse
COHN-S – Certified Occupational Health Nurse - Specialist

Intern Rehabilitation Supplier(an applicant without any of the above certifications) shall (1)submit documentation showing that they are **scheduled to sit** for the examination for CRC, CDMS, CWAVES, CRRN, LPC, CCM, COHN, COHN-S, (2) the application and (3) academic transcript(s). In the event a rehabilitation resident does not become certified or licensed by the appropriate licensing board within a two-year period from the date of initial application, the rehabilitation resident shall be disqualified from providing services to injured employees.

TO RETURN APPLICATION VIA U.S. MAIL, SEND APPLICATION, CERTIFICATES, and/or TRANSCRIPTS AND a $100.00 CHECK OR MONEY ORDER -**MADE PAYABLE TO THE STATE BOARD OF WORKERS' COMPENSATON**- TO:

CHARLES THIGPEN
STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299
404-656-0849

NEW REHAB SUPPLIER REGISTRATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION

PERSONAL DATA

USE TAB BUTTON TO NAVIGATE FORM

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

_____

CITY STATE ZIP

PHONE _____ CELL _____ FAX _____

INTERNET EMAIL* _____ _____

EMPLOYER _____

ADDRESS _____

PHONE _____

ADDRESS AND PHONE NUMBER TO BE USED FOR BOARD CORRESPONDENCE? HOME WORK

This address will be available to the general public however your cell phone number IS NOT available to the public.

*NOTE: Board communication is primarily via email. If you do not have an email address, you are strongly encouraged to obtain one.

Any change in address, phone number or e-mail MUST be reported to Charles Thigpen at thigpenc@sbwc.ga.gov or write to her at the Board address.

GENERAL DATA

DO YOU SPEAK OR WRITE IN A FOREIGN 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 BEEN CERTIFIED OR REGISTERED AS A SUPPLIER BEFORE? YES NO

IF YES, STATE THE SUPPLIER NUMBER ASSIGNED: _____

WERE YOU REGISTERED IN ANY OTHER NAME? YES NO

IF YES, STATE THE NAME(S): _____

EDUCATIONAL DATA

NAME OF SCHOOL	ADDRESS	DATES ATTENDED (MO/YR) (MO/YR) FROM TO	DEGREE OR HIGHEST GRADE COMPLETED

Name(s) listed on Transcripts: _____

_____

_____

****EMPLOYMENT DATA – ATTACHING A RESUME IS *NOT* ACCEPTABLE*****

DESCRIBE YOUR WORK HISTORY BEGINNING WITH YOUR CURRENT OR MOST RECENT JOB. DESCRIBE IN DETAIL THE SPECIFIC DUTIES AND RESPONSIBILITIES FOR EACH JOB. CASE MANAGERS MUST SHOW AT LEAST ONE YEAR EXPERIENCE IN WORKERS COMPENSATION

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

NAME OF SUPERVISOR: _____

DATES FROM AND TO: _____

JOB TITLE: _____

DUTIES: _____

_____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

NAME OF SUPERVISOR _____

DATES FROM AND TO: _____

JOB TITLE: _____

DUTIES: _____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

NAME OF SUPERVISOR: _____

DATES TO AND FROM: _____

JOB TITLE: _____

DUTIES: _____

_____

_____

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 _____

_____

_____

_____

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE WITHIN THE STATE OF GEORGIA?

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

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.

PLEASE ALLOW 20 TO 30 BUSINESS DAYS FOR RECEIPT OF CARD.

SIGNATURE_____**DATE**_____

RETURN APPLICATION AND CHECK OR MONEY ORDER ($100.00 MADE PAYABLE TO *STATE BOARD OF WORKERS' COMPENSATION*), ALONG WITH CERTIFICATION(S) TO:

CHARLES THIGPEN
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299