



STATE BOARD OF WORKERS' COMPENSATION
270 Peachtree Street NW
Atlanta, Georgia 30303-1299
www.sbwc.georgia.gov
(404) 656-5656

REHABILITATION SUPPLIER/CASE MANAGER REGISTRATION APPLICATION

Instructions and Information

CERTIFICATION REQUIREMENTS

A rehabilitation supplier or qualified case manager shall hold one of the following certifications or licenses. See Board Rules 200.1 and 200.2.

Please submit (1) a copy of the certificate(s), 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

To return application via U.S. Mail, send application and certificate(s) and a \$100.00 check or money order made payable to State Board of Workers' Compensation to:

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

INITIAL REGISTRATION FOR REHABILITATION SUPPLIER or QUALIFIED CASE MANAGER

Georgia State Board of Workers' Compensation
Managed Care and Rehabilitation Division

PERSONAL DATA

Name: _____
Last First Middle

Address: _____
Street

City State ZIP

Phone: _____ Cell: _____ Fax: _____

Email:* _____

Employer: _____

Employer Address: _____

Employer 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 Maggie Bessent at Bessentm@sbwc.ga.gov or write to her at the Board address.

GENERAL DATA

Do you speak a language other than English? Yes | No

If yes, state language and number of years: _____

Are you able to communicate with the deaf in ASL? Yes | No

Have you previously been certified or registered as a supplier/case manager with the State Board of Workers' Compensation? Yes | No

If yes, what was your assigned supplier number? _____

Were you registered under another 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

EMPLOYMENT DATA

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 number: _____
Name of supervisor: _____
Employment dates (from/to): _____
Job title: _____
Duties: _____

Employer: _____
Address: _____
Phone number: _____
Name of supervisor: _____
Employment dates (from/to): _____
Job title: _____
Duties: _____

Employer: _____
Address: _____
Phone number: _____
Name of supervisor: _____
Employment dates (from/to): _____
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? Yes | No

If yes, please explain: _____

Will your principal place of business be within the State of Georgia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
---	------------------------------	-----------------------------

Have you ever been convicted of any crime or pleaded *nolo contendere* in a criminal proceeding? Yes | No

If yes, please explain: _____

I have read and am aware of O.C.G.A. § 34-9-200.1 and Board Rules 200.1 and 200.2. 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 the rejection or revocation of registration.

Signature: _____ Date: _____

Return application and check or money order (\$100.00 payable to State Board of Workers' Compensation) with certification(s) to:

Maggie Bessent
State Board of Workers' Compensation
Managed Care and Rehabilitation Division
270 Peachtree Street NW
Atlanta, GA 30303-1299