

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REHABILITATION TRANSMITTAL FORM

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

<b>EMPLOYEE</b>	Occupation	Catastrophic Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	County of Injury	Birthdate
	Diagnosis & Functional Restrictions		Date last plans submitted / If expired, give reason	
			New Plan Expectation Date	

### B. REASON FOR REPORT

- As Directed by the Board
- 90-Day Report for Catastrophic Case
- Non-Catastrophic Medical Care Report
- Preparing for a Rehabilitation conference
- Other (Specify):

### C. ATTACHMENTS

(You must attach all appropriate documents not previously submitted)

- Initial Rehabilitation Report
- Rehabilitation Progress Reports
- Medical / Therapy Reports
- Physical Capacity Evaluation Reports
- Psychological Evaluation Reports
- Vocational Evaluation Reports
- Other (Specify):
- Labor Market Survey
- Job Analysis
- Release to Return to Work
- Training Progress Reports
- Transferable Skills Analysis

### D. SUMMARY

(Please provide a concise statement of activity, progress and recommendations)

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).

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## E. CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

I certify that I have sent copies to the following parties on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at the current addresses below.  
Month Day Year

Signature		Registration No.		
Rehabilitation Supplier Name		Phone Number		Mailing Address
E-mail Address		City	State	Zip Code

<b>EMPLOYEE</b>	Last Name	First Name	M.I.	Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

<b>EMPLOYER</b>	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

<b>INSURER / SELF-INSURER</b>	Name			Mailing Address		
<b>CLAIMS OFFICE</b>	Name					
E-mail Address		Phone Number		City	State	Zip Code

<b>EMPLOYEE'S ATTORNEY</b>	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

<b>EMPLOYER'S ATTORNEY</b>	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

<b>OTHER PARTY OR SITF</b>	Name			Mailing Address		
E-mail Address		Phone Number		City	State	Zip Code

Is this case applicable for Kid's Chance scholarships?  Yes  No If yes, submit application to Kid's Chance, Inc.

## F. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent objections within 20 days of the date sent, the rehabilitation request is approved effective the date of the Certificate of Service. No further correspondence will be issued by the Board.

If there is an objection:

- (1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
- (2) The objection must be received by the Georgia State Board of Workers' Compensation within 20 days of the date of the certificate of service.
- (3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

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