GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST TO CHANGE INFORMATION

Instructions: This form is to be used to correct an employee's name, birthdate, county of injury or claims office that has been listed incorrectly in a claim.

Board Claim Number	Employee Last Name	Employee First Name	M.I.	Date of Injury

	Change From				Change To			
☐ Employee Name								
☐ Birthdate								
☐ County of Injury								
☐ Claims Office	Name				Name			
	Address				Address			
	City				City			
	State		Zip Code		State		Zip Code	

CERTIFICATE OF SERVICE

☐ **I hereby certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, GA 30303-1299.**

Print name	Address		
Signature	City	State	Zip Code
E-mail			GA Bar Number
Phone Number	Date		

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).