WC - PMT(b)

PETITION FOR MEDICAL TREATMENT (b)

FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No.		Employe	ee Last Name		Employee First	Name		M.I.		Date of Injury
			A. C	LAIM INFO	 DRMATION					
Birthdate Body Part Injured					Address			Phone Number		
Employee E-mail	EMPLOYEE			City				State Zip Code		
Employee E-mail				City				State	Zip C	ode
EMPLOYER Name			INSURER/ SELF-INSURER					SBWC# (five digit #)		
Address				CLA	CLAIMS OFFICE Name					
City		State	Zip Code	Addres	ss				Phone N	umber
Phone Number		<u> </u>		City	City			State	Zip C	ode
Employer E-mail				Claims	Claims Office E-mail					
ATTORNEY FO		Name			ORNEY FOR	RFR	Name			
Address		1		Addres						
City		State	Zip Code	City				State	Zip C	ode
GA Bar Number		Phone Number		GA Ba	ır Number			Phone Number		
GA Bai Number				GA Dai Number				THORE NUMBER		
Attorney E-mail				Attorne	ey E-mail					
	B DETITION	TO SHO	W CALISE DE			E ' Q E	All LIDE TO	ATTE	ND	
Attorney E-mail			W CAUSE REG	GARDING	EMPLOYE				ND	
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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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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

 □ D. PETITION TO SUSPEND BENEFITS FOR FAILURE TO ATTEND MEDICAL APPOINTMENT WITH AN AUTHORIZED TREATING PHYSICIAN 								
The employee has failed to attend a medical appointment as agreed or as directed by a previous order of the Board. Petitioner requests the Board to issue a notice of telephonic conference during which the employee and/or the employee's attorney shall be directed to show cause why the employee's disability benefits should not be suspended.								
	E. CERTIF	FICATE OF SERVICE						
This section must be completed.								
I hereby certify that today I have served a copy of:								
☐ SHOW CAUSE PETITION ☐ AGREEMENT ☐ SUSPEND BENEFITS PETITION								
to all of the parties and the authorized treating physician, as appropriate, and have filed this form with the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.								
Print Name		Signature	Date					
Phone Number E	E-mail							

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