WC-R2 REHABILITATION TRANSMITTAL FORM

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REHABILITATION TRANSMITTAL FORM

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

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | Date of Injury |
|---|---|---|---|---|
| | | | | |

## A. IDENTIFYING INFORMATION

| | | | | |
|---|---|---|---|---|
| **EMPLOYEE** | County of Injury | Birthdate | Catastrophic Injury? ☐ Yes ☐ No | Occupation |
| Mailing Address | | | Diagnosis & Functional Restrictions | |
| City | State | Zip Code | Initial Plan ☐ Yes ☐ No | |
| Phone Number | E-mail | | New Plan Expectation Date: | Date Last plan Submitted: |
| **EMPLOYER** | Name | | **INSURER/ SELF-INSURER** | Name |
| Mailing Address | | | **CLAIMS OFFICE** | Name |
| | | | Mailing Address | |
| City | State | Zip Code | City | State / Zip Code |
| | | | SBWC ID# (five digit no.) | Insurer/Self-Insurer File # |
| Phone Number | E-mail | | Phone Number | E-mail |
| **ATTORNEY FOR EMPLOYEE/ CLAIMANT** | Name | | **ATTORNEY FOR EMPLOYER/ INSURER** | Name |
| Mailing Address | | | Mailing Address | |
| City | State | Zip Code | City | State / Zip Code |
| Phone Number | E-mail | | Phone Number | E-mail |
| **OTHER PARTY** | Name | | Mailing Address | |
| E-mail | Phone Number | | City | State / Zip Code |

## 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

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://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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## D. SUMMARY

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

## 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 _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

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

## 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.