GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION CLOSURE

Submitted by: ☐ Claimant ☐ Employer / Insurer ☐ Supplier

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
Mailing Address			Occupation
City	State	Zip Code	Phone Number / E-mail

Fill out information in Section 2 and check appropriate status in Section 3 for return to work cases. If not returned to work, check appropriate status in Section 4. Record costs in Section 5.

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	**REHABILITATION SUPPLIER**	Name / Registration No.
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
Phone Number / E-mail Address		Phone Number / E-mail Address	
Do all parties agree to this closure?		☐ Yes	☐ No

B. RETURN TO WORK INFORMATION

Employer's Business Name				Mailing Address		
Supervisor's Name		Phone Number				
Job Title		Employment Date				
Previous Weekly Wage	Previous Hours per Week	Present Weekly Wage	Present Hours per Week	City	State	Zip Code

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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C. RETURN TO WORK STATUS

- ☐ Closed After Evaluation/Working
- ☐ Same Employer, Same or Modified Job
- ☐ Same Employer, Different Job
- ☐ Same Employer, OJT
- ☐ New Employer, Different Job
- ☐ New Employer, OJT
- ☐ New Employer, After Training
- ☐ Self-Employment
- ☐ RTW After Settlement
- ☐ Other (Specify):

D. NOT RETURNED TO WORK

- ☐ Rehabilitation Not Needed
- ☐ Rehabilitation Not Feasible
- ☐ Medical Goal Attained
- ☐ Settled, Rehabilitation Closed
- ☐ Settled, Rehabilitation Expired
- ☐ Change of Supplier
- ☐ Closed for Training
- ☐ Board Decision (Attach Copy)
- ☐ Other (Specify):

E. REHABILITATION COST

(This section must be completed by rehabilitation supplier)

1. Number of Weeks	2. Medical Care Coordination	3. Vocational Services	4. Total Rehabilitation Costs

F. CERTIFICATE OF SERVICE

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Print or Type Name	Signature

G. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

The Board will issue an Administrative Decision whether or not an objection is received.

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.