GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHAB CONFERENCE

Submitted by: ☐ Claimant ☐ Employer / Insurer ☐ Supplier

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

A. IDENTIFYING INFORMATION

EMPLOYEE	Phone Number	County of Injury	**EMPLOYER**	Name	
Mailing Address			Mailing Address		Phone Number
City	State	Zip Code	City	State	Zip Code
Employee E-mail		Phone Number	Employer E-mail		Phone Number
REHAB SUPPLIER	Name		**INSURER / SELF-INSURER**	Name	
Mailing Address		Phone Number	**CLAIMS OFFICE**	Name	
		Registration Number	SBWC ID #	Mailing Address	
City	State	Zip Code	City	State	Zip Code
Supplier E-mail		Phone Number	E-mail		Phone Number
ATTORNEY FOR EMPLOYEE / CLAIMANT	Name		**ATTORNEY FOR EMPLOYER / INSURER**	Name	
Mailing Address		GA Bar number	Mailing Address		GA Bar number
City	State	Zip Code	City	State	Zip Code
Attorney E-mail		Phone Number	Attorney E-mail		Phone Number

B. ISSUES:

C. CERTIFICATE OF SERVICE

☐ I certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation.

Print Name Here	Signature	Date
Phone Number	E-mail	

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).