

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

ATTORNEY FEE APPROVAL

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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A. IDENTIFYING INFORMATION				
EMPLOYEE	County of Injury	Mailing Address		
E-mail Address	City	State	Zip Code	

B. REQUEST FOR APPROVAL OF ATTORNEY FEE CONTRACT
<input type="checkbox"/> Counsel for the employee/claimant requests approval of the attached fee contract which calls for payment of _____ percent (not to exceed 25%) of all income benefits (which are/have been paid in the amount of \$ _____ per week) commencing _____ / _____ / _____ for a period not to exceed _____ weeks. (Attach supporting documentation) <div style="display: flex; justify-content: space-around; font-size: small;"> (month) (day) (year) </div>

C. REQUEST FOR APPROVAL OF ASSESSED ATTORNEY'S FEE BY CONSENT
Counsel for the employee / claimant _____ other: _____, requests assessment of his / her fee and / or reasonable litigation expenses by consent of parties based on:
<input type="checkbox"/> Reasonable value of services in the amount of \$ _____.
<input type="checkbox"/> Percent (not to exceed 25%) of all income benefits (which are / have been paid in the amount of \$ _____ per week.) commencing _____ / _____ / _____ for a period not to exceed _____ weeks. <div style="display: flex; justify-content: space-around; font-size: small;"> (month) (day) (year) </div>
<input type="checkbox"/> Reasonable litigation expenses in the amount of \$ _____. (Attach supporting documentation)

D. AGREEMENT OF ALL PARTIES AND COUNSEL FOR RESOLUTION OF FEE LIEN DISPUTE
All parties and counsel agree for the Board to approve payment of fees as follows: Specify which attorney should receive which fee, and whether the fee should be assessed as a lump sum amount or as percentage based on income benefits, the date commenced, and the percentage to be applied (not to exceed 25%).

E. CERTIFICATE OF SERVICE					
<input type="checkbox"/> I certify the fee which I am requesting represents the fair and reasonable value of my services, and complies with O.C.G.A. §34-9-108 and Board Rule 108. I have today sent a copy of this request to all counsel and unrepresented parties in this action.			CONSENTED TO BY:		
Signature		Date	Signature		Date
Print Name			Print Name		
E-mail		GA Bar Number	E-mail		GA Bar Number
Mailing Address		Phone Number	Mailing Address		Phone Number
City	State	Zip Code	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 <http://www.sbwcc.ga.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).