

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE DOCUMENTATION OF TEMPORARY PARTIAL DISABILITY PAYMENTS

Instructions: Complete this form when the maximum temporary partial disability benefits are not being paid and file with the Board. When paying weekly temporary partial disability income benefits, based upon an actual return to work file a Form WC-262 with the Board at 13 week intervals or when such benefits are suspended, whichever comes first. When filing the Form WC-262 with the Board, send a copy to the employee and the employee's counsel, if represented.

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		EMPLOYER	Name	
Mailing Address		Phone Number		Mailing Address	
City		State	Zip Code	City	
State		Zip Code		State	
City		State	Zip Code	City	
Employee E-mail			Employer E-mail		
INSURER/ SELF-INSURER	Name		E-mail	Phone Number	
CLAIMS OFFICE	Name		Mailing Address		
SBWC ID #			City	State	Zip Code

B. TEMPORARY PARTIAL DISABILITY BENEFITS

	START DATE	END DATE	AVERAGE WEEKLY WAGE	TOTAL GROSS EARNINGS	DIFFERENCE (Weekly Wage - Gross Earnings)	PAYMENT Difference x $\frac{2}{3}$ Not to exceed maximum stated in §34-9-262
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
TOTALS						

C. CERTIFICATION

<input type="checkbox"/> I hereby certify that to the best of my knowledge the total payments listed are correct as the available information indicates.		
Print Name	E-mail	Date

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.sbcw.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).