GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST TO CHANGE INFORMATION ON A PREVIOUSLY FILED FORM WC-14

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Address		
Employee E-mail			City	State	Zip Code
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name	SBWC# (five digit #)
Address			**CLAIMS OFFICE**	Name	
			Claims Address		
City	State	Zip Code	City	State	Zip Code
Employer E-mail			Claims E-mail		
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Address	GA Bar Number		Address	GA Bar Number	
City	State	Zip Code	City	State	Zip Code
Attorney E-mail			Attorney E-mail		

B. INFORMATION TO BE AMENDED

The information provided on the Form WC-14 dated _____ is amended as follows:

❑ Date of Injury (Can only be amended +/- 30 days from previous date of injury.)	Change Date of Injury From:		Change Date of Injury To:			
❑ Correct an Employer's Name Only	Existing Employer Name:		Corrected Employer Name:			
❑ Dismiss a Party	Party Name		Address			
❑ Employer ❑ Insurer ❑ Claims Office	City		State		Zip Code	
❑ Add Additional Hearing Issues Only (DO NOT USE THIS SECTION TO ADD PARTIES.)						

C. AFFIRMATION OF FILING PARTY

❑ I, (the person whose name appears above), attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

D. ENTRY OF APPEARANCE

❑ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102 (fee contract or WC-102B has been previously filed or is attached).

E. CERTIFICATE OF SERVICE

❑ I certify that I have today sent a copy of this form to all parties named above, and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	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).