GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF REPRESENTATION OF ANY PARTY OTHER THAN A CLAIMANT OR EMPLOYEE BY AN ATTORNEY

(This form is not to be filed by an attorney for claimant / employee)

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

A. IDENTIFYING INFORMATION

EMPLOYEE	Phone Number	County of Injury
Address		
City	State	Zip Code
Employee E-mail		

EMPLOYER	Name	
Address		
City	State	Zip Code
Employer E-mail	Phone Number	

INSURER / SELF-INSURER	Name	
CLAIMS OFFICE	Name	
Address		
City	State	Zip Code
Claims E-mail	Phone Number	

PARTY AT INTEREST OR SITF	Name	
Address		
City	State	Zip Code
Party E-mail	Phone Number	

ATTORNEY FOR EMPLOYEE/CLAIMANT	Name	
Address		
City	State	Zip Code
GA Bar Number		
Attorney E-mail	Phone Number	

ATTORNEY FOR EMPLOYER/INSURER	Name	
Address		
City	State	Zip Code
GA Bar Number		
Attorney E-mail	Phone Number	

B. NOTICE

This serves notice that Attorney:

Name			Telephone Number
Firm Name			Fax Number
Address			E-mail Address
City	State	Zip Code	GA Bar Number

is counsel in this case for the following named party / parties:

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, 270 Peachtree Street N.W., Atlanta, GA 30303-1299

Signature	E-mail Address	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.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).