WC-262 WAGE DOCUMENTATION

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.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury		**EMPLOYER**	Name	
Address	Phone Number		Address	Phone Number	
City	State	Zip Code	City	State	Zip Code
Employee E-mail			Employer E-mail		
INSURER/ SELF-INSURER	Name		SBWC ID# (five digit no.)	Phone Number	
CLAIMS OFFICE	Name		Address		
Claims Office E-mail			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 $^2/_3$ 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

❑ I hereby certify that to the best of my know ledge 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.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).