

STATE BOARD OF WORKERS' COMPENSATION
REHABILITATION REGISTRATION
RENEWAL REHAB SUPPLIER REGISTRATION

**RETURN RENEWAL APPLICATION WITH CHECK OR MONEY ORDER PAYABLE TO THE
STATE BOARD OF WORKERS COMPENSATION FOR \$50.00 TO:**

Managed Care and Rehabilitation Division
270 Peachtree Street, NW
Atlanta, GA 30303-1299
ATTN: YVONNE R. WATKINS

Rehabilitation Renewals available online at <http://sbwc.georgia.gov> from October 1st through November 30th of each year

ALL APPLICATIONS FOR RENEWAL MUST BE RECEIVED BY NOVEMBER 30th of each year

ANY LATE APPLICATION WILL BE SUBJECT TO A LATE FEE AND/OR PENALTIES. REHABILITATION SUPPLIERS ARE RESPONSIBLE FOR COMPLIANCE WITH ALL RULE CHANGES AND ARE RESPONSIBLE FOR OBTAINING THE RENEWAL APPLICATION.

Any person who fails to renew on or before November 30th, shall be penalized an additional \$25.00. Any person who is delinquent on or after January 1 of each year shall be penalized an additional amount up to \$100.00. Any supplier who has not renewed his/her registration by November 30th of the year following their supplier registration expiration date, shall not be eligible for renewal, and will be required to submit a new application to become a rehabilitation supplier in accordance with Section 200.1



COPIES OF GEORGIA WORKERS' COMPENSATION LAW, RULES AND REGULATIONS
ANNOTATED,
WHICH GOVERN REHABILITATION ACTIVITIES, MAY BE OBTAINED FROM OUR WEB SITE OR
FROM:
LEXIS LAW PUBLISHING
POST OFFICE BOX 7587
CHARLOTTESVILLE, VA 22906-7587
1-800-562-1197



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Managed Care and Rehabilitation
270 PEACHTREE ST., NW
ATLANTA, GA 30303
(404) 656-0849

Supplier: #0

RENEWAL REHAB SUPPLIER REGISTRATION

PERSONAL DATA

USE TAB BUTTON TO NAVIGATE APPLICATION

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STATE) (ZIP)

PHONE: _____ CELL: _____ FAX# _____ EMAIL: _____

EMPLOYER -
W/ADDRESS: _____

GA REHABILITATION SUPPLIER # _____

ADDRESS/PHONE /EMAIL TO BE USED FOR BOARD CORRESPONDENCE (This will be available to the general public)

MAILING ADDRESS _____
(CITY) (STATE) (ZIP)

TELEPHONE: _____ EMAIL ADDRESS _____

ANY CHANGE IN ADDRESS, PHONE NUMBER OR E-MAIL ADDRESS MUST BE REPORTED TO YVONNE R. WATKINS, IN THE MANAGED CARE AND REHABILITATION DIVISION OF THE STATE BOARD OF WORKERS' COMPENSATION. CHANGES SENT TO OTHER DIVISIONS WILL NOT BE PROCESSED.

NOTICE: CERTIFIED REHABILITATION SUPPLIER

COPIES OF ALL CERTIFICATIONS MUST ACCOMPANY RENEWAL APPLICATION ON YEAR OF RENEWAL WITH THE CERTIFYING BOARD.

NOTICE: UNCERTIFIED REHABILITATION SUPPLIER (REGISTERED PRIOR TO 1985)

ATTACH EVIDENCE OF 30 CONTACT HOURS OF CONTINUING EDUCATION UNITS THAT HAVE BEEN APPROVED BY ONE OF THE CERTIFYING BOARDS. REFER TO RULE 200.1(f) (1)(I)

DO YOU WRITE OR SPEAK A FORGEIN LANGUAGE:

YES NO

IF YES, STATE LANGUAGE AND NUMBER OF YEARS:

ARE YOU ABLE TO COMMUNICATE WITH THE DEAF IN SIGN LANGUAGE?

YES NO

HAVE YOU EVER HAD ANY BUSINESS OR PROFESSIONAL LICENSE REVOKED, SUSPENDED OR ANNULLED OR HAD ANY OTHER DISCIPLINARY ACTION TAKEN AGAINST YOU? IF YES,

EXPLAIN

HAVE YOU EVER BEEN REGISTERED UNDER ANY OTHER NAME?

YES NO

IF YES, STATE THE NAME

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE IN GEORGIA:

YES NO

HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OR PLED NOLO CONTENDRE IN A CRIMINAL PROCEEDING?

YES NO

IF YES, EXPLAIN

I HAVE READ, AND AM AWARE OF, O.C.G.A. 34-9-200.1 AND RULE 200.1. ALL OF THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE STATE BOARD OF WORKERS' COMPENSATION TO MAKE ANY INVESTIGATION OF THE FOREGOING INFORMATION. I UNDERSTAND THAT ANY OMISSION OR MISREPRESENTATION MAY RESULT IN REJECTION OR REVOCATION OF REGISTRATION.

SIGNATURE _____ DATE _____

I am a catastrophic supplier and volunteer to serve as a catastrophic rehabilitation mentor.

Please check one: Yes No