GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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

Instructions: The purpose of this form is to change mistakes concerning certain information (Employee Name, SSN or Board Tracking #, Date of Injury, or County of Injury only) on a previously filed Form WC-14. This form shall not be used to change an address of record, add additional parties, or additional dates of injury.

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

A. CHANGED INFORMATION

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

	Change From	Change To
❑ Employee Name		
❑ SSN or Board Tracking #		
❑ Date of Injury		
❑ County of Injury		
Reasons for change(s) above:		

B. CERTIFICATION

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

Print name here	Address		
Signature	City	State	Zip Code
E-mail			GA Bar number
Phone Number	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).