GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REHABILITATION TRANSMITTAL FORM

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	Catastrophic Injury? ❑ Yes ❑ No	County of Injury	Birthdate

Diagnosis & Functional Restrictions	Date last plans submitted / If expired, give reason	New Plan Expectation Date

SECTION 2 REASON FOR REPORT

- ❑ As Directed by the Board
- ❑ 90-Day Report for Catastrophic Case
- ❑ Non-Catastrophic Medical Care Report
- ❑ Preparing for a Rehabilitation conference
  (Attach Rehabilitation Progress Reports and Medical Reports)
- ❑ Other (Specify):

SECTION 3 ATTACHMENTS

(You must attach all appropriate documents not previously submitted)

- ❑ Initial Rehabilitation Report
- ❑ Rehabilitation Progress Reports
- ❑ Medical / Therapy Reports
- ❑ Physical Capacity Evaluation Reports
- ❑ Psychological Evaluation Reports
- ❑ Vocational Evaluation Reports
- ❑ Other (Specify):
- ❑ Labor Market Survey
- ❑ Job Analysis
- ❑ Release to Return to Work
- ❑ Training Progress Reports
- ❑ Transferable Skills Analysis

SECTION 4 SUMMARY

(Please provide a concise statement of activity, progress and recommendations)

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).

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SECTION 5 CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

❑ I certify that I have mailed copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses below.

Signature		Registration No.		
Rehabilitation Supplier Name	Telephone	Address		
E-mail Address		City	State	Zip Code

EMPLOYEE	Last Name	First Name	M.I.	Address	
E-mail Address	Telephone Number			City	State / Zip Code
EMPLOYER	Name			Address	
E-mail Address	Telephone Number			City	State / Zip Code
INSURER / SELF-INSURER	Name			Address	
CLAIMS OFFICE	Name				
E-mail Address	Telephone Number			City	State / Zip Code
EMPLOYEE'S ATTORNEY	Name			Address	
E-mail Address	Telephone Number			City	State / Zip Code
EMPLOYER'S ATTORNEY	Name			Address	
E-mail Address	Telephone Number			City	State / Zip Code
SITF	Name			Address	
E-mail Address	Telephone Number			City	State / Zip Code

Is this case applicable for Kid's Chance scholarships? ❑ Yes ❑ No If yes, submit application to Kid's Chance, Inc.

SECTION 6 APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent written objections within 20 days of the date mailed, the rehabilitation request is approved effective the date of the certificate of service. No further correspondence will be issued by the Board. If there is an objection:

(1) The Objection must be in writing.
(2) It must be received by the Georgia State Board of Workers' compensation within 20 days of the date of the Certificate of Service.
(3) A Certificate of Service must be completed stating that copies of the written objections were placed in the mail to all parties and the principal rehabilitation supplier the same date as the Certificate of Service.