

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
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A. IDENTIFYING INFORMATION					
EMPLOYEE	County of Injury		Address		
Employee E-mail		City		State	Zip Code
ATTORNEY FOR EMPLOYEE / CLAIMANT	Name		EMPLOYER	Name	
Address		Address			
City		State	Zip Code	City	
GA Bar number		Employer E-mail			
Attorney E-mail		INSURER / SELF-INSURER	Name		
PARTY AT INTEREST	Name		CLAIMS OFFICE	Name	
Address		Address			SBWC ID # (five digit no.)
City		State	Zip Code	City	
Party E-mail		Claims E-mail			

B. NOTICE					
This serves notice that Attorney: _____					
of the firm: _____					
at mailing address: _____					
Telephone Number	City		State	Zip Code	
Fax Number	E-mail Address			GA Bar Number	
Is counsel in this case for the following named party / parties:					

C. CERTIFICATION		
<input type="checkbox"/> 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.sbcw.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).