

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## CASE PROGRESS REPORT

Initial    Supplement    Final    Reopened

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION				
<b>EMPLOYER</b>	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment

B. PAYMENT TYPE Enter actual amounts paid	RATE	WEEKS	DAYS	TOTAL PAYMENTS
<input type="checkbox"/> (a) Temporary Total				
<input type="checkbox"/> (b) Temporary Partial				
<input type="checkbox"/> (c) Permanent Partial				
<input type="checkbox"/> (d) Death				
<input type="checkbox"/> (e) Stipulation/Settlement				
<input type="checkbox"/> (f) Advances				

C. PAYMENTS	TOTAL LOST TIME PAYMENTS TO DATE
1 Total Weekly Benefits	
2 Physician Benefits	
3 Hospital Benefits	
4 Pharmacy Benefits	
5 Physical Therapy	
6 Chiropractic	
7 Other (Medical)	
8 Rehabilitation / Vocational (excluding all of the above)	
9 Late Payment Penalties	
10 Assessed Attorney's Fees	
11 Burial	
<b>Totals</b>	

<b>D. Recovery code:</b> <input type="checkbox"/> for Subrogation <input type="checkbox"/> for Overpayment <input type="checkbox"/> for SITF <input type="checkbox"/> Other
<b>Remarks</b>

**E.**  I certify that the total payments are as correct as the available information indicates.

Type or Print Name	Signature		Date
Address		E-mail	
City	State	Zip Code	Phone Number
Insurer/Self Insurer Name		Claims Office Name	

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).