

____ Initial
____ Change

GEORGIA STATE BOARD OF WORKERS' COMPENSATION REQUEST FOR REHABILITATION

TO BE USED BY ANY PARTY TO THE CASE

Board Use Only	
Reviewer	
Date	Status

____ REQUEST REHABILITATION
____ REOPEN REHABILITATION

____ REQUEST A CHANGE OF SUPPLIER
____ REQUEST CATASTROPHIC DESIGNATION

County of Injury

SECTION I. IDENTIFYING INFORMATION

1. _____ 2. _____ 3. _____
Employee Name Social Security Number Date of Injury

4. _____ 5. No Yes _____ 6. _____
Occupation Catastrophic Injury Date of Birth

7. _____ 8. _____
Treating Physician Physician's Speciality

9. _____
Diagnosis - Secondary Condition

SECTION II. NOTICE OF REHABILITATION REQUEST

This section must be completed to request an initial appointment, request rehabilitation be reopened, request a change of supplier, or request an extension of services beyond 26 weeks.

INITIAL APPOINTMENT: Number of Days From Date of Injury: _____
Supplier's Name: _____ Registration No. _____ Expiration Date _____
Intern's Name (if any) _____ Registration No. _____ Expiration Date _____

REOPEN REHABILITATION: Date of Previous Closure: _____
Supplier's Name: _____ Registration No. _____ Expiration Date _____
Intern's Name (if any) _____ Registration No. _____ Expiration Date _____

CHANGE OF SUPPLIER:
From: Supplier's Name: _____ Registration No. _____ Expiration Date _____
To: Supplier's Name: _____ Registration No. _____ Expiration Date _____
Intern's Name (if any) _____ Registration No. _____ Expiration Date _____

EXTENSION OF REHABILITATION BEYOND 26 WEEKS: Number of Weeks: _____

SECTION III. REASON FOR REQUEST

Please complete for all requests. Use a second sheet if needed. Include copies of appropriate documents.

Do all parties agree to this request? No Yes

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. §34-9-19 and §34-9-19).

SECTION IV. CERTIFICATE OF SERVICE This section must be completed by the requesting party.

I CERTIFY THAT I HAVE MAILED COPIES TO THE FOLLOWING PARTIES ON _____ AT THE CURRENT
ADDRESSES BELOW. DATE

Employee Address _____ Telephone _____

Employer Address _____ Telephone _____

Insurance Adjuster Address _____ Telephone _____

Employee's Attorney Address _____ Telephone _____

Employer's Attorney Address _____ Telephone _____

Subsequent Injury Trust Fund Address _____ Telephone _____

Current Supplier Address _____ Telephone _____
Reg. No. _____
Exp. Date _____

Proposed Supplier Address _____ Telephone _____
Reg. No. _____
Exp. Date _____

Intern's Name (if any) _____ Reg. No. _____
Exp. Date _____

SIGNATURE _____ Representing: employee employer/insurer

COMPANY/FIRM NAME _____ Telephone _____

ADDRESS _____

SECTION V. APPROVAL/OBJECTIONS, FIFTEEN (15) DAY NOTICE

ABSENT WRITTEN OBJECTIONS WITHIN 15 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 15 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

ANY OBJECTIONS RECEIVED BY THE BOARD WILL BE PROCESSED IN ACCORDANCE WITH O.C.G.A. §9-11-6 (e).

THE EMPLOYER/INSURER IS REQUIRED TO PROVIDE COPIES OF ALL AVAILABLE MEDICAL NARRATIVES AND OTHER SUPPORTING DOCUMENTATION TO THE ASSIGNED REHABILITATION SUPPLIER.