

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

- NOTICE OF CLAIM
- REQUEST FOR HEARING
- REQUEST FOR MEDIATION

FOR BOARD USE ONLY <input type="checkbox"/> Have File <input type="checkbox"/> No File <input type="checkbox"/> Entered

A. IDENTIFYING INFORMATION

Employee Name _____	Soc. Security No. _____
Address _____	Date of Injury _____
_____	County of Injury _____
Employer Name _____	

Insurer _____	

Servicing Agent _____	

Attorney for _____	
Employee/Claimant _____	

Attorney for _____	
Employer/Insurer _____	

B. NOTICE OF CLAIM

1. _____
Part of Body Injured
2. _____
First Date Disabled
3. _____
Date of Death (if applicable)
4. Briefly describe accident.

5. List treating physician(s):

C. ACTION REQUESTED/STATUS

_____ 1. A mediation conference is requested at this time.	_____ 5. Add additional issues (see reverse).
_____ 2. I do not request a hearing at this time.	
_____ 3. A request for hearing is being filed by:	
<input type="checkbox"/> Employee	<input type="checkbox"/> Claimant(s) for death benefits (list names & addresses):
<input type="checkbox"/> Employer	
<input type="checkbox"/> Insurer	
<input type="checkbox"/> Other (specify): _____	
_____ 4. Additional dates of accident which will be involved (if any): _____	

(Complete a separate form WC-14 for each date of accident)

D. ENTRY OF APPEARANCE

I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 and/or a notice of representation in compliance with Board Rule 102.

E. CERTIFICATE OF SERVICE

I hereby certify that I have today sent a copy of this form to all of the parties named above, and have sent this form, to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299. <http://www.sbcw.georgia.gov>

_____	_____
Print Name Here	Signature
_____	_____
Phone	Date

IF YOU ARE REQUESTING A HEARING OR MEDIATION CONFERENCE TO OBTAIN BENEFITS OR RELIEF, YOU MUST COMPLETE THE BACK OF THIS FORM IN DETAIL.

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).

NOTICE TO CLAIMANT

1. If you need assistance in filling out this form, you may call the State Board of Workers' Compensation in Atlanta at (404) 656-3818 or 1-800-533-0682. You are not required to hire an attorney to file a claim or hearing request with the Board. However, if you choose to hire an attorney the referral number for the Georgia Bar Association is 1-800-334-6865.
2. If you do not know the name of the employer's insurance company, you may call (404) 656-3692 or 1-800-743-5436 to see if the information is available.

**IF YOU ARE REQUESTING A HEARING OR MEDIATION CONFERENCE
TO OBTAIN BENEFITS OR RELIEF, YOU MUST COMPLETE THE
FOLLOWING IN DETAIL AND PROVIDE (5) ADDITIONAL COPIES
OF THIS FORM TO THE BOARD**

State Board of Workers' Compensation
270 Peachtree St., NW
Atlanta, Georgia 30303-1299
<http://www.sbwc.georgia.gov>

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- INCOME BENEFITS:** If you want income benefits, identify here the type of benefits you want (temporary total, temporary partial, or permanent partial disability benefits), and the specific dates for which they are requested.

 - MEDICAL BENEFITS:** If you are requesting medical benefits, list the names of the providers of services and the amounts due. (Do not send copies of bills to the Board). If mileage is requested, provide a summary.

 - ASSESSED ATTORNEY FEES/PENALTIES:** State the legal ground and list the code sections which support your request. If the basis for this request is failure to comply with an order or award, give the date the order was issued.

 - SUSPENSION/TERMINATION REQUEST:** If you wish to suspend or terminate the benefits of an employee or claimant, specify the reason here, and cite the effective date.
 - Failure to accept suitable employment, effective _____
 - Failure to cooperate with medical treatment, effective _____
 - Failure to cooperate with rehabilitation, effective _____
 - Other: _____

 - OTHER:**

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