

**GEORGIA STATE BOARD OF WORKERS' COMPENSATION
EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION**

_____ County of Injury

SECTION I. IDENTIFYING INFORMATION

1. _____ Employee Name	2. _____ Social Security Number	3. _____ Date of Injury
4. _____ Occupation	5. _____ Date of Birth	6. _____ Treating Physician / Specialty
7. _____ Diagnosis and Secondary Conditions		

SECTION II. NOTICE OF REQUEST FOR CATASTROPHIC DESIGNATION AND APPOINTMENT OF A CATASTROPHIC REHABILITATION SUPPLIER

This section must be completed by an employee who is requesting catastrophic designation of his or her injury, if s/he wishes to request the appointment of a specific Board-registered catastrophic rehabilitation supplier.

The Board will issue an administrative decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an administrative decision naming that supplier to work with this employee.

Name of Requested Rehabilitation Supplier: _____ Reg. No. _____

SECTION III. THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's education level: _____

Employee's work history for the last 15 years, including physical requirements of each job (pounds lifted, hours standing, sitting, walking)

Job Title:	Physical Requirements:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ATTACH TO THIS FORM A STATEMENT FROM THIS EMPLOYEE'S AUTHORIZED TREATING PHYSICIAN(S) INDICATING THE PHYSICIAN(S)' OPINION OF THE EMPLOYEE'S WORK ABILITY. THIS STATEMENT MUST BE DATED NO MORE THAN ONE YEAR PRIOR TO THE CERTIFIED MAILING DATE OF THIS FORM. THIS MUST BE SUBMITTED EVEN IF THE EMPLOYEE IS RECEIVING SOCIAL SECURITY DISABILITY (SSDI) OR SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS.

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).

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** () _____

Proposed Supplier Address _____ **Telephone** () _____
_____ **Reg. No.** _____

SIGNATURE _____

COMPANY/FIRM NAME _____

ADDRESS _____

SECTION V. APPROVAL/OBJECTIONS, TWENTY (20) DAY NOTICE

Absent a written objection within 20 days of the date mailed, the request for catastrophic designation will be considered unopposed and will be approved. The Board WILL issue an administrative decision on this matter, whether or not an objection is received. If there is an objection, it must be in writing, must be copied to all case parties and to any/all involved rehabilitation suppliers, and will be processed in accordance with O.C.G.A. §9-11-6 (e).

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).