

GEORGIA STATE BOARD OF WORKERS' COMPENSATION REQUEST FOR REHABILITATION CLOSURE

| | |
|----------------|--------|
| Board Use Only | |
| Reviewer | |
| Date | Status |

_____ County of Injury

SECTION I. IDENTIFYING INFORMATION

| | | |
|---------------------------|--|----------------------------|
| 1. _____ Employee Name | 2. _____ Social Security Number | 3. _____ Date of Injury |
| 4. _____ Occupation | 5. No <input type="checkbox"/> Yes <input type="checkbox"/> Catastrophic Case | 6. _____ Date of Birth |

FILL OUT INFORMATION IN SECTION II AND CHECK APPROPRIATE STATUS IN SECTION III FOR RETURN TO WORK CASES. IF NOT RETURNED TO WORK, CHECK APPROPRIATE STATUS IN SECTION IV. RECORD COSTS IN SECTION V.

SECTION II. RETURN TO WORK INFORMATION

| | |
|---|----------------------------------|
| 1. _____ Employer's Business Name | |
| 2. _____ Employer's Business Address | |
| _____ City State Zip | |
| 3. _____ Supervisor's Name | 4. _____ Area Code/Telephone |
| 5. _____ Job Title | 6. _____ Employment Date |
| 7. _____ Previous Weekly Wage | 8. _____ Previous Hours Per Week |
| 9. _____ Present Weekly Wage | 10. _____ Present Hours Per Week |

SECTION III. RETURN TO WORK STATUS

| | |
|--|-----|
| 1. Closed After Evaluation/Working | () |
| 2. Same Employer, Same or Modified Job | () |
| 3. Same Employer, Different Job | () |
| 4. Same Employer, OJT | () |
| 5. New Employer, Different Job | () |
| 6. New Employer, OJT | () |
| 7. New Employer, After Training | () |
| 8. Self-Employment | () |
| 9. RTW After Settlement | () |
| 10. Other: | () |

SECTION IV. NOT RETURNED TO WORK

| | |
|------------------------------------|-----|
| 1. Rehabilitation Not Needed | () |
| 2. Rehabilitation Not Feasible | () |
| 3. Medical Goal Attained | () |
| 4. Settled, Rehabilitation Closed | () |
| 5. Settled, Rehabilitation Expired | () |
| 6. Change of Supplier | () |
| 7. Closed for Training | () |
| 8. Board Decision (Attach Copy) | () |
| 9. Other: _____ | () |

SECTION V. REHABILITATION COST

**(THIS SECTION MUST BE COMPLETED
BY REHABILITATION SUPPLIER)**

| | |
|-------------------------------|--------------|
| 1. NUMBER OF WEEKS: | _____ |
| | <u>COSTS</u> |
| 2. MEDICAL CARE COORDINATION | \$ _____ |
| 3. VOCATIONAL SERVICES | \$ _____ |
| 4. TOTAL REHABILITATION COSTS | \$ _____ |

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 VI. CERTIFICATE OF SERVICE (THIS SECTION MUST BE COMPLETED BY THE PRINCIPAL SUPPLIER)

I CERTIFY THAT I HAVE DISCUSSED THE PROPOSED CASE CLOSURE WITH THE EMPLOYEE AND OTHER PARTIES TO THE CASE AND HAVE MAILED COPIES ON _____ TO THE FOLLOWING PARTIES 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 () _____

SIGNATURE _____ Registration No. _____
Rehabilitation Supplier _____ Telephone _____
Address _____

DO ALL PARTIES AGREE TO THIS CLOSURE? Yes No

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

ABSENT WRITTEN OBJECTIONS WITHIN 20 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 20 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).

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