GEORGIA STATE BOARD OF WORKERS' COMPENSATION

	d additiona	Complete a new Form WC-14 to add an addit ditional space, do not alter this form, but instea			ut instead at	l attach additional sheets. Must be typed			or printed in		1
Board Claim No.		Employee Last Name				Employee First Name			M.I.		Date of Injury
				A. C	LAIM INF	ORMATION					
EMPLOYEE	Birthdate		County of Inj	ury	Ma	ailing Address					
Employee E-mail					Cit	у			State	Zip C	ode
	Name					IOUDED!	Name	<u> </u>		I SE	BWC# (five digit #)
EMPLOYER	INAIIIC					ISURER/ ELF- INSURER	Ivanie			36	svvo# (live digit #)
Mailing Address					Ma	ailing Address	· ·			ı	
City			State	Zip Code	Cit	у			State	Zip C	ode
Employer E-mail					Ins	surer E-mail					
ATTORNEY FOR Name EMPLOYEE/CLAIMANT						TTORNEY FOR MPLOYER/INSU		Name			
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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.sbwc.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).

WC-14 REVISION 7/2021

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NOTICE OF CLAIM