



## GEORGIA CRIME VICTIMS COMPENSATION PROGRAM

104 Marietta Street, NW • Suite 440 • Atlanta, GA • 30303-2743  
404/657-2222 • 800/547-0060 • 404/463-7652 (Fax) • 404/463-7650 (TTY)

### WORK RELEASE FORM

An application for Economic Support benefits was submitted to the Georgia Crime Victims Compensation Program (CVCP) for consideration. To help the CVCP make the best possible decision in determining eligibility, we would appreciate your assistance by providing the below information. This form is only required if the victim was out of work more than one (1) week. This form is only required if the victim was out of work more than one (1) week.

#### Patient/Victim

Name: \_\_\_\_\_

Last 4 of SSN: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Crime: \_\_\_\_/\_\_\_\_/\_\_\_\_

Claim Number: \_\_\_\_\_

|  |                              |   |
|--|------------------------------|---|
| 1. Date(s) patient/victim was under your care.   | From: ____/____/____         | To: ____/____/____  |
| 2. Is patient/victim permanently disabled and unable to work?<br>(a) if No, dates patient/victim was <b>unable</b> to work due to injuries sustained during victimization.<br>(b) Date patient/victim is/was released to return to work. | Yes <input type="checkbox"/> | No <input type="checkbox"/><br>From: ____/____/____ To: ____/____/____<br>_____/_____/_____ |
| 3. Please describe the patient's/victim's condition that made him/her <b>unable</b> to perform work-related activities:<br>_____<br>_____  |                              |   |

\_\_\_\_\_  
Medical Provider (print name)

\_\_\_\_\_  
Medical Provider Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone No.: \_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_\_  
Composite State Board of  
Medical Examiners License No.

**PLEASE NOTE: TO BE VALID, this form must be faxed or mailed by the MEDICAL PROVIDER.**

*An Equal Opportunity Employer*