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?	Yes ☐	No ☐
(a) if No, dates patient/victim was **unable** to work due to injuries sustained during victimization.	From: ____/____/____	To: ____/____/____
(b) Date patient/victim is/was released to return to work.	_____/_____/_____	

3. Please describe the patient's/victim's condition that made him/her **unable** to perform work-related activities:

_____

_____

_____
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.

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