CLAIMANT'S CONSENT TO PAY ATTORNEY AND DOCTOR FEES

This form must be submitted to the Workers' Compensation Commission in accordance with COMAR 14.09.04.02. All fees and costs must be itemized on the form below.

WCC Claim Number:

Claimant:

Employer:

Insurer:

I, the undersigned hereby certify that my attorney has explained to me the amounts allowable by the Commission as counsel fee under the Maryland Workers' Compensation Commission Schedule of Attorneys' Fees, COMAR 14.09.04.03 and I consent to the award of a fee to my attorney in accordance with the schedule.

I further consent to the allowance of a fee in accordance with the Maryland Workers' Compensation Commission Guide of Medical and Surgical Fees, COMAR 14.09.08 to my physician(s) for services performed at my or my counsel's request.

Attorney Fees: Copies of receipts for advanced expenses *MUST* be attached. DO NOT attach ledger sheets. Medical Fees: Copies of medical bills with CPT Codes *MUST* be attached for consideration. DO NOT attach medical reports.

Please attach additional pages as necessary

I further agree that the fees allowed may be deducted from the compensation benefits awarded to me, in the manner prescribed by the Workers' Compensation Commission or as directed by law.

Claimant Signature

Date

I hereby certify that (1) I have earned the amounts allowable by the Commission as counsel fee under COMAR 14.09.04.03 and, (2) any costs for which the undersigned is seeking repayment actually were advanced by the undersigned attorney.

Attorney Signature

Attorney Name

Attorney Telephone Number