

WORKERS' COMPENSATION COMMISSION



Claim Number

Date

Claimant

Employer

Insurer

Healthcare Provider

The following issues are hereby raised by (choose one)

Claimant/Attorney	Non Insured/ Attorney	SIF
Employer/Attorney	Healthcare Provider/Attorney	UEF
Insurer/Attorney		

1. Did the employee sustain an injury causally related to an accident which arose out of and in the course of employment?
2. Is the disability of the employee (TT/TP/PT/PP) causally related to the accidental injury?
3. Did the employee sustain a compensable hernia within the meaning of the Workers' Compensation Act?
4. Did the employee sustain an occupational disease?
5. Average weekly wage
6. Limitations
7. Jurisdiction
8. Statutory employment
9. Medical expenses (creditors and/or amount)
10. Vocational rehabilitation
11. Attorney fees/costs
12. Penalties
13. Temporary total disability from _____ to _____
14. Nature and extent of permanent disability to the following part or parts of the body:

15. Other (specify)

16. Authorization for medical treatment (you must briefly specify treatment requested)

17. Temporary total from _____ to present and continuing.

I HEREBY CERTIFY that on this _____ day of _____, _____, service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

Name of Party Raising Issues

Signature