



WORKERS' COMPENSATION COMMISSION

REQUEST FOR ACTION ON FILED ISSUES

This form is to be used only for the actions identified below and is to be submitted without a cover letter.

WCC CLAIM NUMBER:

CLAIMANT'S NAME:

EMPLOYER:

INSURER:

If hearing has been scheduled: DATE

LOCATION

SELECT ONLY ONE ACTION:

Withdrawal of issues previously filed (Filing party only).

Dismissal of claim (On behalf of claimant only).

“Set With” scheduling:

The following numbered claim(s) have pending issues and should be set with this claim when it is scheduled for hearing:

Change of Venue:

Requestor **MUST** complete the Location and Date Information above

Requested Location:

Reason for Change:

REQUESTED BY:

Claimant Claimant's Attorney Employer/Insurer Employer/Insurer Attorney SIF/UEF

CERTIFICATION OF SERVICE

I hereby certify that on this _____ day of _____, _____, a copy of this Request and any attached documentation was mailed to all parties and their attorneys. Failure to notify opposing counsel prior to the hearing date may result in a penalty or fine to be assessed against a party withdrawing issues.

Name

Signature

Telephone Number

WCC Form H25R (February 2007)