WORKERS' COMPENSATION COMMISSION

REQUEST TO STRIKE APPEARANCE OF COUNSEL

WCC Claim Number: _____ **Date of Accident:** _____

Claimant: _____

Insurer/Self-Insurer: _____

Employer: _____

The Counsel listed below, *who currently represents the following party* in the above-referenced claim, requests that said attorney's appearance be stricken from this case:

◯ **Claimant** ◯ **Employer/Insurer** ◯ **SIF** ◯ **UEF** ◯ **Healthcare Provider**

ATTORNEY INFORMATION: **(Complete in Adobe Reader, type or print only)**

Name of Counsel: _____

WCC Attorney Registration No: _____

Street Address: _____

City/State/Zip: _____

Telephone: _____

CERTIFICATION OF SERVICE

I hereby certify that on this ____ day of _____, 20___ , a copy of this Request to Strike Appearance of Counsel was mailed to all parties and/or their attorneys.

_____

Signature

CLICK HERE TO CLEAR THE FORM

10 East Baltimore Street • Baltimore, Maryland 21202-1641
410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.state.md.us