WORKERS' COMPENSATION COMMISSION

ISSUES

Claim Number _____ Date _____

Claimant _____

Employer _____

Insurer _____

Healthcare Provider _____

The following issues are hereby raised by (choose one)

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

☐ 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

Address of Party Raising Issues, include Street address, City, State and Zip Code

CLICK HERE TO CLEAR THE FORM