WORKERS' COMPENSATION COMMISSION

ISSUES

Claim Number _____ **Date** _____

Claimant Name _____

Employer _____

Insurer _____

The following issues are hereby raised by (choose one)

- ☐ Claimant
- ☐ Claimant's Attorney
- ☐ Employer
- ☐ Employer's Attorney
- ☐ Insurer
- ☐ Insurer's Attorney
- ☐ Non Insurer
- ☐ Non Insurer's 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 _____ , _____ a copy of the above issues and any attached documentation was mailed to all parties and their attorneys.

Name of Party Raising Issues

Signature

CLICK HERE TO CLEAR THE FORM

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