**Before the**

**WORKERS' COMPENSATION BOARD**

**State of Oregon**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Request Type:** |  | Initial |  | Supplemental | | |  | Amended | | |  | Consolidate w/WCB # | | |  | | |
| **Requested by:** |  | Atty/Claimant | | |  | Claimant | | |  | Insurer/Processor | | |  | Employer | |  | DCBS |

**In the Matter of the Compensation of Request for Hearing and Specification of Issues**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | Date of Injury | | | | | | |  |
| Address |  | | | | | Claim # |  | | | | | | |
| (only one claim number per form) | | | | | | | |
| Phone # |  | | | | | WCD File # | | | | |  | | |
|  | | | | | |  | | | | | |  | |
| Claimant's Attorney | | | |  | | Employer | | | |  | | | |
| Oregon State Bar # | | | | |  | Address | | | |  | | | |
| Attorney Firm | | |  | | |
| Address | |  | | | | Insurer | |  | | | | | |
| Address | | |  | | | | |
| Phone # | |  | | | |

**Parties must notify WCB of any address changes**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A hearing is requested for the reason(s) checked below:** | | | | |  | | | |
| **A** DENIAL *(date)* | |  | | | **N** ORDER ON RECONSIDERATION  **attach copy** | | | |
|  **B** Compensability - complete claim denial | | | | |  **Y** Classification *(disabling/nondisabling)* | | | |
|  **X** Partial denial after a claim acceptance | | | | |  **I** Premature closure | | | |
|  **Z** Challenge to notice of acceptance | | | | |  **E** Temporary disability | | | |
|  **V** Worker noncooperation | | | | | Period sought |  | | |
|  **K** Aggravation | | | | |  **H** Permanent partial disability | | | |
|  **L** Responsibility | | | | |  **G** Permanent total disability | | | |
|  **C** Medical services (ORS 656.245) | | | | | **Q** OTHER *(Explain and cite ORS)* | | | |
| **M** NONCOMPLYING EMPLOYER ORDER | | | | |
| **O** TEMPORARY DISABILITY | | | | | **P** DIRECTOR'S ORDER **attach copy** | | | |
|  **R** Rate | | | | | **S** PENALTY *(Cite ORS)* | |  | |
|  **D** Period sought | | |  | | **T** ATTORNEY FEE *(Cite ORS)* | | |  |
| **F** SUPPLEMENTAL TEMPORARY DISABILITY | | | | | **W** COSTS | | | |
| (2nd Employer) Period sought | | | |  |  | | | |
|  |  | | | |  | | | |

* **INTERPRETER WILL BE NEEDED - Language:** Yes  No
* Amount in controversy is LESS than $1000 (ORS 656.291).  Yes  No
* Compensation stayed *(Carrier appeal of Order on Reconsideration).*  Yes  No
* All day is required for hearing.  Yes  No
* Half day is required for hearing.  Yes  No

**NOTICE TO OPPOSING PARTY:**

**The requesting party demands copies of all medical reports and all other documents pertaining to this claim regardless of whether the responding party intends to rely on them at hearing.**

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Signature of Requester Date