**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