**Before the**

# WORKERS' COMPENSATION BOARD

**State of Oregon**

## In the Matter of the Compensation of \*\*\* RESPONSE TO ISSUES \*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Claimant's Name: |  | WCB Case No: |  |
| Claim No: |  | Assigned ALJ: |  |
| Date of Injury: |  | Hearing Date: |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| In response to the issues raised by claimant, the insurer or self-insured employer: | | | | | | | | | |
|  | ADMITS | | | DENIES | | | |  |  |
| (ABX) | |  |  | |  | | That claimant has a compensable injury/disease or new/omitted condition | | |
| (Z) | |  |  | |  | | That the notice of acceptance is inaccurate | | |
| (V) | |  |  | |  | | That claimant has cooperated with the claim investigation | | |
| (K) | |  |  | |  | | That claimant sustained an aggravation | | |
| (L) | |  |  | |  | | That the employer is responsible | | |
| (C) | |  |  | |  | | That claimant is entitled to medical services | | |
| Denial Date: | | | | | |  |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (M) |  |  |  | That the parties are subject to the Workers' Compensation Act |
| (OD) |  |  |  | That claimant is entitled to temporary disability benefits |
| (R) |  |  |  | That temporary disability benefits were paid at an incorrect rate |
| (F) |  |  |  | That claimant is entitled to supplemental temporary disability benefits |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (Y) |  |  |  | That the claim should be classified as disabling | |
| (I) |  |  |  | That the claim was prematurely closed | |
| (E) |  |  |  | That claimant is entitled to additional temporary disability benefits | |
| (HG) |  |  |  | That claimant is entitled to additional permanent disability benefits | |
| Reconsideration Order Date: | | | | |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Q) |  |  |  | Other (explain and cite ORS) |  | | | |
| (P) |  |  |  | That the Director’s Order should be affirmed (date) | | |  | |
| (S) |  |  |  | That claimant is entitled to a penalty (cite ORS) | |  | | |
| (T) |  |  |  | That claimant is entitled to an attorney fee (cite ORS) | | | |  |
| (W) |  |  |  | That claimant is entitled to costs | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The insurer or self-insured employer hereby cross-appeals and contends: | | | | | | | | |
|  |  | That the award of temporary disability benefits is excessive | | | | | | |
|  |  | That the award of permanent disability benefits is excessive | | | | | | |
| **INTERPRETER WILL BE NEEDED.** | | |  | Yes |  | No | **LANGUAGE** |  |

**Notice to Opposing Party:**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| By: |  | |  | Date: |  |
| OSB No.: | |  |  | Client: |  |