**Before the**

# WORKERS' COMPENSATION BOARD

**State of Oregon**

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

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

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| 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: |  |       |

|  |  |  |  |  |
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| (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 |

|  |  |  |  |  |
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| (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: |       |

|  |  |  |  |  |  |
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| (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 |

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| 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.**

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