**Before the**
**WORKERS' COMPENSATION BOARD**
**State of Oregon**

## In the Matter of the Compensation of

Name _____
Address _____
_____
Phone # _____

Claimant's Attorney _____
Oregon State Bar Number _____
Attorney Firm _____
Address _____
_____
Phone # _____

## Request for Hearing and Specification of Issues

Date of Injury _____
Claim # _____
(only one claim number per form)

WCD File # _____

Employer _____
Address _____
_____

Insurer _____
Address _____
_____

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

**A hearing is requested for the reason(s) checked below:**

- ☐ **A** DENIAL *(date)* _____
  - ☐ **B** Compensability - complete claim denial
  - ☐ **X** Partial denial after a claim acceptance
  - ☐ **Z** Challenge to notice of acceptance
  - ☐ **V** Worker noncooperation
  - ☐ **K** Aggravation
  - ☐ **L** Responsibility
  - ☐ **C** Medical services
- ☐ **M** NONCOMPLYING EMPLOYER ORDER
- ☐ **O** TEMPORARY DISABILITY
  - ☐ **R** Temporary disability rate
  - ☐ **D** Procedural temporary disability
  - ☐ **F** Supplemental disability
    Period sought _____
- ☐ **N** ORDER ON RECONSIDERATION **attach copy**
  - ☐ **Y** Classification *(disabling/nondisabling)*
  - ☐ **I** Premature closure
  - ☐ **E** Substantive temporary disability
    Period sought _____
  - ☐ **H** Permanent partial disability
  - ☐ **G** Permanent total disability
- ☐ **Q** OTHER *(Explain and cite ORS)* _____
- ☐ **P** DIRECTOR'S ORDER **attach copy**
- ☐ **S** PENALTY *(Cite ORS)* _____
- ☐ **T** ATTORNEY FEE *(Cite ORS)* _____
- ☐ **W** COSTS
- ☐ **U** OFFSET

- **INTERPRETER WILL BE NEEDED - Language:** _____ ☐ Yes ☐ No
- The amount in controversy is LESS than $1000. ☐ Yes ☐ No
- All day is required for hearing. ☐ Yes ☐ No
- Stress claim *(Such claims will be set for all day unless otherwise requested)* ☐ Yes ☐ No
- Compensation stayed *(Employer/insurer appeal of WCD Reconsideration Order)* ☐ Yes ☐ No
- Please consolidate this request for hearing with the following pending case(s) regarding this claim or claimant: WCB Case No(s)_____ ☐ Yes ☐ No

_____ _____
Signature of Requester Date

Request by
- ☐ Attorney/Claimant
- ☐ Claimant
- ☐ Insurer/Processing Agent
- ☐ Employer
- ☐ DCBS

**NOTICE TO OPPOSING PARTY:**

**The requester demands copies of all medical reports and all other documents pertaining to this claim, whether or not the requesting party intends to rely on them at hearing.**

Date Received

Rev 7/13