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** Rate
  - ☐ **D** Procedural entitlement
    Period sought _____
- ☐ **N** ORDER ON RECONSIDERATION **attach copy**
  - ☐ **Y** Classification *(disabling/nondisabling)*
  - ☐ **I** Premature closure
  - ☐ **D** 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** TEMPORARY DISABILITY 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