

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

In the Matter of the Compensation of _____

***** RESPONSE TO ISSUES *****

WCB Case No: _____

Claimant's Name _____ Claim No: _____

(N) Reconsideration Order Date: _____ (A) Denial Date: _____

In response to the issues raised by the claimant, the insurer or self-insured employer:

ADMITS DENIES

- | | | | |
|------|--------------------------|--------------------------|---|
| (BX) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant sustained a work-related accidental injury or occupational disease. |
| (V) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant cooperated with the claims investigation. |
| (Z) | <input type="checkbox"/> | <input type="checkbox"/> | That a condition has been incorrectly omitted (scope of acceptance). |
| (OD) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to additional temporary disability. |
| (HG) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to additional permanent disability. |
| (I) | <input type="checkbox"/> | <input type="checkbox"/> | That the claim was prematurely closed. |
| (Y) | <input type="checkbox"/> | <input type="checkbox"/> | That the claim should be classified as disabling. |
| (K) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant sustained an aggravation of the injury/disease on _____
(date) |
| (L) | <input type="checkbox"/> | <input type="checkbox"/> | That the employer is responsible. |
| (M) | <input type="checkbox"/> | <input type="checkbox"/> | That the parties were subject to the Workers' Compensation Act. |
| (P) | <input type="checkbox"/> | <input type="checkbox"/> | Director's Order Date: _____ |
| (Q) | <input type="checkbox"/> | <input type="checkbox"/> | Other - Explain & Cite ORS: _____ |
| (R) | <input type="checkbox"/> | <input type="checkbox"/> | That the claimant was paid temporary disability at an incorrect rate. |
| (S) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to a penalty for _____ |
| (T) | <input type="checkbox"/> | <input type="checkbox"/> | Attorney Fees - Cite ORS: _____ |
| (W) | <input type="checkbox"/> | <input type="checkbox"/> | Costs |
| (U) | <input type="checkbox"/> | <input type="checkbox"/> | Temporary Disability Offset. |

The Insurer or Self-Insured Employer hereby Cross-Appeals and Contends:

- That the award of permanent disability is excessive.
- That the award of temporary disability is excessive.
- Entitlement to an offset for an overpayment of temporary disability benefits in the amount of \$ _____

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

INTERPRETER WILL BE NEEDED. Yes No **LANGUAGE** _____

Dated _____, 20 _____ For: _____

By: _____ OSB #: _____