

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

In the Matter of the Compensation of

Request for Hearing and Specification of Issues

Name _____	Date of Injury _____
Address _____	Claim # _____
	(only one claim number per form)
Phone # _____	SS # _____ (optional)
	WCD File # _____
Claimant's Attorney _____	Employer _____
Oregon State Bar Number _____	Address _____
Attorney Firm _____	
Address _____	Insurer _____
	Address _____
Phone # _____	

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

<input type="checkbox"/> A DENIAL (date) _____ <input type="checkbox"/> B Compensability - complete claim denial <input type="checkbox"/> X Partial denial after a claim acceptance <input type="checkbox"/> Z Challenge to notice of acceptance <input type="checkbox"/> V Worker noncooperation <input type="checkbox"/> K Aggravation <input type="checkbox"/> L Responsibility <input type="checkbox"/> O Own Motion <input type="checkbox"/> C Medical Services <input type="checkbox"/> Compensability/Causation <input type="checkbox"/> M NONCOMPLYING EMPLOYER ORDER <input type="checkbox"/> TTD/TPD <input type="checkbox"/> R Rate <input type="checkbox"/> D Procedural entitlement Period sought _____	<input type="checkbox"/> N ORDER ON RECONSIDERATION attach copy <input type="checkbox"/> Y Classification (disabling/nondisabling) <input type="checkbox"/> I Premature closure <input type="checkbox"/> D Substantive TTD/TPD Period sought _____ <input type="checkbox"/> E Scheduled disability <input type="checkbox"/> F Unscheduled disability <input type="checkbox"/> G Permanent total disability <input type="checkbox"/> Q OTHER (Explain and cite ORS) _____ <hr/> <input type="checkbox"/> P DIRECTOR'S ORDER attach copy <input type="checkbox"/> S PENALTY (Cite ORS) _____ <input type="checkbox"/> T ATTORNEY FEE (Cite ORS) _____ <input type="checkbox"/> U TEMPORARY DISABILITY OFFSET
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- **INTERPRETER WILL BE NEEDED** Yes No **LANGUAGE** _____
- 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 give this request for hearing a different WCB case number and hearing date from any pending case(s) regarding this claim or claimant** 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.