

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

Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Supplemental <input type="checkbox"/> Amended <input type="checkbox"/> Consolidate w/WCB # _____
Requested by: <input type="checkbox"/> Atty/Claimant <input type="checkbox"/> Claimant <input type="checkbox"/> Insurer/Processor <input type="checkbox"/> Employer <input type="checkbox"/> DCBS

In the Matter of the Compensation of

Request for Hearing and Specification of Issues

Name _____ Address _____ Phone # _____ Claimant's Attorney _____ Oregon State Bar # _____ Attorney Firm _____ Address _____ Phone # _____	Date of Injury _____ Claim # _____ (only one claim number per form) WCD File # _____ Employer _____ Address _____ Insurer _____ Address _____
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Parties must notify WCB of any address changes

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"/> C Medical services (ORS 656.245) <input type="checkbox"/> M NONCOMPLYING EMPLOYER ORDER <input type="checkbox"/> O TEMPORARY DISABILITY <input type="checkbox"/> R Rate <input type="checkbox"/> D Period sought _____ <input type="checkbox"/> F SUPPLEMENTAL TEMPORARY DISABILITY (2 nd Employer) 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"/> E Temporary disability Period sought _____ <input type="checkbox"/> H Permanent partial disability <input type="checkbox"/> G Permanent total disability <input type="checkbox"/> Q OTHER (Explain and cite ORS) _____ <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"/> W COSTS

- **INTERPRETER WILL BE NEEDED - Language:** _____ Yes No
- Amount in controversy is LESS than \$1000 (ORS 656.291). Yes No
- Compensation stayed (Carrier appeal of Order on Reconsideration). Yes No
- All day is required for hearing. Yes No

NOTICE TO OPPOSING PARTY:

The requesting party demands copies of all medical reports and all other documents pertaining to this claim regardless of whether the responding party intends to rely on them at hearing.

Signature of Requester

Date