

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

**In the Matter of the Compensation of**

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

Claimant's Name: \_\_\_\_\_ WCB Case No: \_\_\_\_\_

Claim No: \_\_\_\_\_ Assigned ALJ: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Hearing Date: \_\_\_\_\_

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

ADMITS    DENIES

- |       |                          |                          |   |
|-------|--------------------------|--------------------------|---|
| (ABX) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant has a compensable injury/disease or new/omitted condition |
| (Z)   | <input type="checkbox"/> | <input type="checkbox"/> | That the notice of acceptance is inaccurate                             |
| (V)   | <input type="checkbox"/> | <input type="checkbox"/> | That claimant has cooperated with the claim investigation               |
| (K)   | <input type="checkbox"/> | <input type="checkbox"/> | That claimant sustained an aggravation                                  |
| (L)   | <input type="checkbox"/> | <input type="checkbox"/> | That the employer is responsible  |
| (C)   | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to medical services                           |

Denial Date: \_\_\_\_\_

- |      |                          |                          |   |
|------|--------------------------|--------------------------|---|
| (M)  | <input type="checkbox"/> | <input type="checkbox"/> | That the parties are subject to the Workers' Compensation Act           |
| (OD) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to temporary disability benefits              |
| (R)  | <input type="checkbox"/> | <input type="checkbox"/> | That temporary disability benefits were paid at an incorrect rate       |
| (F)  | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to supplemental temporary disability benefits |

- |      |                          |                          |   |
|------|--------------------------|--------------------------|---|
| (Y)  | <input type="checkbox"/> | <input type="checkbox"/> | That the claim should be classified as disabling                      |
| (I)  | <input type="checkbox"/> | <input type="checkbox"/> | That the claim was prematurely closed                                 |
| (E)  | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to additional temporary disability benefits |
| (HG) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to additional permanent disability benefits |

Reconsideration Order Date: \_\_\_\_\_

- |     |                          |                          |   |
|-----|--------------------------|--------------------------|---|
| (Q) | <input type="checkbox"/> | <input type="checkbox"/> | Other (explain and cite ORS) _____                            |
| (P) | <input type="checkbox"/> | <input type="checkbox"/> | That the Director's Order should be affirmed (date) _____     |
| (S) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to a penalty (cite ORS) _____       |
| (T) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to an attorney fee (cite ORS) _____ |
| (W) | <input type="checkbox"/> | <input type="checkbox"/> | That claimant is entitled to costs                            |

The insurer or self-insured employer hereby cross-appeals and contends:

- ☐ That the award of temporary disability benefits is excessive
- ☐ That the award of permanent disability benefits is excessive

**INTERPRETER WILL BE NEEDED.**    ☐ Yes    ☐ No    **LANGUAGE** \_\_\_\_\_

**Notice to Opposing Party:**

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

By: \_\_\_\_\_ Date: \_\_\_\_\_

OSB No.: \_\_\_\_\_ Client: \_\_\_\_\_