

**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: _____