

**State of Utah - Labor Commission**  
**Division of Adjudication**  
160 East 300 South, 3<sup>rd</sup> Floor, P.O. Box 146615  
Salt Lake City, Utah 84114-6615  
(801) 530-6800  
laborcommission.utah.gov  
**Note: PLEASE TYPE OR PRINT IN BLACK INK**

	<b>NOTICE OF FILING APPLICATION FOR HEARING FOR TERMINATION OR REDUCTION OF COMPENSATION</b>
Employer (Petitioner)	
Employer's Mailing Address	
City State Zip Code	
Petitioner's Worker's Comp Insurance Carrier	
Insurance Carrier's Mailing Address	
City State Zip Code	
<b>vs.</b>	
Employee (Respondent)	
Employee's Mailing Address	
City State Zip Code	
Respondent's Telephone Number	

**PETITIONER HEREBY NOTIFIES RESPONDENT THAT AN APPLICATION FOR  
TERMINATION OR REDUCTION OF COMPENSATION HAS BEEN FILED WITH THE UTAH  
LABOR COMMISSION.**

**THIS APPLICATION FOR HEARING REQUESTS THE COMMISSION TO:**

\_\_\_\_\_ **TERMINATE TEMPORARY TOTAL DISABILITY COMPENSATION**

\_\_\_\_\_ **REDUCE WEEKLY TEMPORARY TOTAL DISABILITY COMPENSATION BY \$ \_\_\_\_\_**

**A HEARING WILL BE SCHEDULED BY THE ADJUDICATION DIVISION OF THE  
COMMISSION WITHIN 30 DAYS OF FILING THIS APPLICATION.**

