

Utah Labor Commission

Adjudication Division

160 East 300 South, 3rd Floor, P.O. Box 146615

Salt Lake City, Utah 84114-6615

(801) 530-6800

casefiling@utah.gov

Note: PLEASE TYPE OR PRINT IN BLACK INK

Employer (Petitioner)
Employer's Mailing Address
City, State and Zip Code
Employer's E-Mail Address
Petitioner's Workers' Comp Insurance Carrier
Insurance Carrier's Mailing Address
City, State and Zip Code
Insurance Carrier's E-Mail Address
vs.
Respondent (Employee)
Respondent's Mailing Address
City, State and Zip Code
Respondent's Phone Number

NOTICE OF FILING APPLICATION FOR HEARING FOR TERMINATION OR REDUCTION OF COMPENSATION

Petitioner hereby notifies respondent that an Application for Hearing 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.

Printed Name of Attorney for Petitioner State Bar #

Signature of Attorney for Petitioner

Attorney's Mailing Address

City State Zip Code

Telephone Number

FAX

E-Mail Address

I certify that on this _____ day of _____, 20____, a copy of the attached Notice of Request of Termination or Reduction of Compensation in the case of _____, Petitioner vs. _____, Respondent, was mailed first class, postage prepaid, to the respondent at the following address:

Respondent Name

Respondent Address

City State Zip Code

Print Name

Signature