Form 001
10/07/16

State of Utah - Labor Commission
Division of Adjudication
160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800
casefiling@utah.gov (for cases north of Nephi)
sgcasefiling@utah.gov (for cases south of Nephi)
Note: PLEASE TYPE OR PRINT CLEARLY IN INK.

_____ Petitioner _____ Other Name(s) Used By Petitioner **vs.** _____ Respondent (Employer) _____ Respondent's Mailing Address _____ City, State And Zip Code _____ Respondent's Worker's Comp Insurance Carrier***** _____ Insurance Carrier's Mailing Address _____ City, State And Zip Code	**APPLICATION FOR HEARING** **Industrial Accident Claim** (NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned) I request that a Claims Resolution Conference be scheduled to resolve the issues checked below ☐ **YES** ☐ **NO** *****It is the Petitioner's obligation to provide the mailing address and phone number for respondent's insurance carrier. If you do not have this information, you may obtain it on the Labor Commission website or the Industrial Accidents Division Workers' Compcheck. You may also contact the employer or the Industrial Accidents Division.

PETITIONER STATES AS FOLLOWS:

1a. I sustained an injury by accident arising out of and in the course of my employment with the above named employer on the following date: Month _____ Date ___ Year _____.

1b. I sustained an injury by repetitive trauma arising out of and in the course of my employment with the above named employer during the period of Month _____ Date ___ Year ____ to Month _____ Date ____ Year_____.

2. The accident occurred at the following location: _____

3. Describe the accident with a focus on how you were injured: _____
_____
_____
_____

4. The injuries I sustained from the accident are: _____
_____

5. My birth date is:_____

6. At the time of the accident, my wage was $_____ per_____, and I was working _____hours per week. I _____ was _____ was not married and had _____dependent children. If you earned wages on some other basis, such as $1/mile or $5/piece, please explain how much you earned each week: _____
_____

7. THE BENEFITS I AM SEEKING ARE:

Please mark an "X" next to any issues you want resolved and attach relevant supporting documentation for each issue marked. Do not check benefits which do not apply to your case.

For more information about what benefits you may be entitled to, please see our website http://laborcommission.utah.gov/divisions/IndustrialAccidents/Claims.html. You may also find this guide useful: http://laborcommission.utah.gov/media/pdfs/industrialaccidents/pubs/EEGuide.pdf)

A. ☐ **Medical Expenses.** Specify the providers and amounts billed to date. You may need to update this information in your pretrial disclosures. _____
_____
_____

B. ☐ **Recommended Medical Care.** Specify services or treatment. You may need to update this information in your pretrial disclosures._____
_____
_____

C. ☐ **Temporary Total Disability Compensation.** Time off work from _____ to _____; from _____ to _____; from _____ to: _____.

D. ☐ **Temporary Partial Disability Compensation.** Reduced wages from _____ to _____; from _____ to _____; from _____ to: _____.

E. ☐ **Permanent Partial Disability Compensation.** Specify impairment rating(s) for each injury. You must also attach medical records or a Summary of Medical Records form showing the impairment rating calculated by a physician. _____

F. ☐ **Permanent Total Disability Compensation.** This means that you are permanently unable to work. (**Important:** You must complete the Permanent Total Disability Fact Sheet for permanent total disability compensation claims.)

G. ☐ **Travel Expenses.** (**Important:** If you claim reimbursement for travel expenses, you must attach a separate sheet with the name of the medical provider, the date(s) of service, and the mileage to the provider for each date.)

H. ☐ **Unpaid Interest.**

I. ☐ **Other.** Specify:_____

8. Coordination of Benefits with Your Private Health Insurance Company

If you want your private health insurance company to pay for your medical expenses while your workers compensation case is being litigated, you must provide us with the following information. Failure to provide us with this information will mean that your private health carrier will not have to pay for your medical expenses. If you do not have this information now, you can provide it to us later – but payment of your medical expenses will start only once your private health insurer has received notice. The Labor Commission will inform your private health insurer of their obligations; you do not need to contact them yourself.

Primary private health insurance company:

Name of carrier: _____
Address: _____
Phone number: _____
Policy number: _____
Name of insured: _____

Secondary private health insurance company:

Name of carrier: _____
Address: _____
Phone number: _____
Policy number: _____
Name of insured: _____

For more information regarding the Utah Coordination of Benefits Act (Utah Code Ann. §31A-22-619.6), please see the Utah Labor Commission's website at
http://laborcommission.utah.gov/divisions/Adjudication/index.html

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I verify that the above information is true and correct to the best of my information and belief.	
_____ Name of Petitioner's Attorney State Bar #	_____ Petitioner's Signature Date
_____ Attorney's Signature	_____ Petitioner's Mailing Address
_____ Attorney's Mailing Address	_____ City/State/Zip Code
_____ City/State/Zip Code	(_____)_____ Petitioner's Telephone Number
(___)_____ Telephone Number	_____ Petitioner's E-Mail Address
(___)_____ FAX	
_____ Attorney's E-Mail Address	

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Documents That MUST Be Filed With Your Application For Hearing

☐ Form 307 Medical Treatment Provider List

- You may attach additional pages if necessary.

☐ Form 308 Authorization to Disclose Health Information (HIPAA Compliant)

☐ Form 113a Summary of Medical Record

- You may submit other medical records that provide medical support for your claims but you must highlight the language that shows the relationship between the injury and your employer.

☐ Permanent Total Disability Fact Sheet

- Only required if the claim is for permanent total disability compensation.

Third Party Administrator

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim, please include that information:

_____
Name of Adjuster or Third Party Administrator

_____ _____
Mailing Address for Adjuster or Third Party Administrator Email Address

_____
City/State/Zip Code

IMPORTANT:

Failure to include completed and signed forms with all of the necessary supporting documentation will result in the Application for Hearing being returned to you for completion. If the returned Application for Hearing is not completed and refiled with the requested supporting documents within 60 days, the Application for Hearing will be dismissed without prejudice, which means that you can file a new Application for Hearing once you have collected all of the information required.

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Permanent Total Disability Fact Sheet

You must complete this form if you are applying for permanent total disability compensation.

1. Date my disability began: _____.

2. Last grade I completed in school: _____.

3. Diplomas/degrees/licenses/or specialized training I completed: _____
_____
_____
_____

4. I can speak and/or read and write in English: _____
_____

5. Attach copies of written physical restrictions provided by your doctor that prevent your return to work, or which make it more difficult for you to return to work. Please make sure to highlight the restrictions.

6. These are the jobs I worked at or have applied for since the industrial injury:
_____
_____
_____
_____
_____

7. My Employment History: (Attach additional sheets if necessary).

Employer	Dates of Employment	Job Description