

Objection to Tentative Order Determining the Percentage of Permanent Partial Disability Compensation

Instructions

- * Print or type all information.
- * This form is to be used by the injured worker and employer and/or their authorized representatives to object to the tentative order determining a percentage of permanent partial disability compensation.
- * This objection should be sent to the local Industrial Commission office.

INJURED WORKER INFORMATION	
Injured worker name	Claim number
Social Security Number	Date of injury

NAME AND ADDRESS OF PERSON FILING OBJECTION		
Name		
Address		
City	State	9-digit ZIP Code
Please indicate your status		
<input type="checkbox"/> Injured worker	<input type="checkbox"/> Injured worker representative	<input type="checkbox"/> Employer
<input type="checkbox"/> Employer representative		

INFORMATION FROM TENTATIVE ORDER	
Date of order	Date received

ADDITIONAL INFORMATION	
Choose one: <input type="checkbox"/> I intend to file additional medical evidence. <input type="checkbox"/> I do not intend to file additional medical evidence.	

STATEMENT OF OBJECTION	
<p><i>I hereby OBJECT to the TENTATIVE ORDER that determined the percentage of permanent partial disability compensation in the above numbered claim, and request the matter to be set for a hearing before an Industrial Commission district hearing officer.</i></p> <p><i>I understand that if this OBJECTION is not received within twenty days of the date I received the TENTATIVE ORDER, that order shall become effective and compensation shall be paid as provided in that order.</i></p> <p>CERTIFICATE OF SERVICE: I certify that I have served a copy of this objection to the tentative order determining a percentage of permanent partial disability compensation to the <input type="checkbox"/> injured worker's representative and / or <input type="checkbox"/> employer's representative (check one or both), on _____, 20____. If there is no representative, I have mailed a copy to the injured worker and / or employer.</p> <p>By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this objection by the <input type="checkbox"/> injured worker <input type="checkbox"/> employer.</p>	
Signature	Date