HEARING APPLICATION

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Please read instructions on top sheet.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 5.04(1)(m)].

1. Employee Name, Address, City, State, Zip	2. Employer Name, Address, City, State, Zip (At Time of Injury)	3. WC Insurance Carrier, Address, City, State, Zip
1A. Employee Social Security No.	Federal Employer Identification Number [If Known]	
1B. Employee Telephone No. (include area code) ( )	2A. Employer Telephone No. (include area code) ( )	3A. Insurance Carrier Telephone No. (area code) ( )
1C. Date of Birth (mo/day/yr) — Sex ☐ M ☐ F	2B. Nature of Employer Business	3B. Date of Injury (mo/day/yr)
1D. Employee Attorney (if any) Name & Full Address	2C. Employee Occupation When Injured	3C. Last Date Employee Worked Before Disability
	2D. Employee Gross Weekly Wage When Injured	3D. Date Notice of Injury Given to Employer (mo/day/yr):
	ANSWER QUESTIONS 4 TO 4C IF CLAIM IS MADE FOR DEATH BENEFIT	
	4. Name of Deceased and Date of Death	4B. Are You a Dependent of the Deceased? ☐ Yes ☐ No
1E. Attorney's Telephone No. (include area code) ( )	4A. Relation to Deceased ☐ Husband ☐ Wife ☐ Child ☐ Other	4C. Did You Live With the Deceased? ☐ Yes ☐ No

5. Describe the nature of the disability, parts of the body affected, how the injury or death occurred.

6. Check the boxes below for which compensation is being sought and specify detail, if known:

6A. ☐ Temporary Total Disability (day, month and year)
From To From To

6B. ☐ Temporary Partial Disability From To	6C. ☐ Permanent Total Disability Starting Date:	6D. ☐ Permanent Partial Disability %
6E. ☐ Medical Expenses Denied $	6F. Transportation Costs (mileage, etc.) $	6G. ☐ Other:

7. Names and Addresses of Medical Practitioners Who Treated Applicant:

8. Has Employee Returned to Work?
☐ Yes ☐ No If Yes, On What Date? ______ Did Employee Return to Same Employer? ☐ Yes ☐ No

9. Were Medical Expenses Paid? ☐ Yes ☐ No If Yes, By Whom?

10. Are You Currently Receiving Worker's Compensation Disability Benefits? ☐ Yes ☐ No

11. Have Sickness and Accident Benefits/Income Continuation Been Paid for Lost Wages? ☐ Yes ☐ No

11A. If Yes, Indicate by Whom and the Amounts.

12. Will Be Ready for a Formal Hearing On or After the Date Indicated Here:

13. I Request the Hearing Be Scheduled at the Wisconsin City Shown Here:

14.

Employee Signature Date Signed

If represented, do you agree that an attorney's fee, fixed by the department at no more than 20% of your recovery, may be paid directly from the compensation you recover? ☐ Yes ☐ No

15. **FOR OFFICE USE ONLY:**

HR PT NR

Issues______	☐ GL35	☐ GL35A	☐ GL48
Length______	☐ GL33	☐ GL70	☐ GL34
Date ______	☐ GL33A	☐ GL39	☐ GL31