

REQUEST THAT CLAIM BE ASSIGNED FOR HEARING

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File# _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____ Employee's Name			_____ Employer's Name			_____ Telephone Number			
_____ Address			_____ Employer's Address			_____ City	_____ State	_____ Zip	
_____ City		_____ State	_____ Zip		_____ Insurance Carrier				
_____ Home Telephone		_____ Work Telephone		_____ Carrier's Address			_____ City	_____ State	_____ Zip
_____ Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> F Sex	_____ Date of Birth		_____ Carrier's Telephone Number			_____ Fax Number		

I, _____, respectfully notify you that the above named parties have failed to reach an agreement in regard to compensation, and I request a hearing.

We have been unable to agree because (state reason with specificity): _____

Employee believes he or she is entitled to the following workers' compensation benefits (check all that apply):

- Payment of compensation for days missed (give dates): _____
- Payment of medical expenses/treatment: _____
- Payment for permanent partial disability: _____
- Payment for permanent and total disability: _____
- Payment for scars: _____
- Other: _____

Has claimant participated in mediation? Yes No

Date of injury: _____ Part of body: _____

City and county wherein injury occurred: _____

Estimated length of hearing: _____

Below is a list of names and addresses of all witnesses, including doctors, whose testimony is to be taken by the requesting party. Doctors outside the county of hearing are not required to attend this hearing.

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**MAIL TO: NCIC - DOCKET SECTION
4336 MAIL SERVICE CENTER
RALEIGH, NC 27699-4336
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/**

When a date of hearing is set, I respectfully request the Commission to send me signed subpoenas for my witnesses. When I receive these subpoenas, I will deliver them to the Sheriff of the county or counties in which each witness resides so that the subpoenas may be served.

(Signature of party requesting hearing, or attorney)

(Title)

(Address: street and number, city, state and zip)

(Date of notice)

CERTIFICATION

I, _____, hereby certify that this case is ready for hearing. This case will be set in the county where the injury occurred unless good reason is shown for a different location. If you want the hearing in a different county, name the county below and your reason for that location.

(County)

(Reason for setting)

(Signature)

Note: A copy of this form must be sent to opposing parties. The original of this form must be sent to the Industrial Commission at the address below: