



Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No. _____
 Ins. Co. File No. _____
 Date of Injury _____

NOTICE AND APPLICATION FOR HEARING

Employee:

Name: _____
 Street: _____
 City: _____
 State: _____ Zip: _____
 Home Phone Number: _____
 Work Phone Number: _____
 Email Address: _____

Employer:

Name: _____
 Insurance Carrier: _____
 TPA Name: _____
 Adjuster Name: _____
 Phone Number and Extension: _____

The accident upon which claim for compensation is based, occurred on the _____ day
 of _____, 20____ in the town of _____
 and the state of _____

Briefly state the issue(s) in dispute and attach supporting evidence (attach additional pages as necessary and include documentation including medical records):

The applicant seeks:

- | | |
|--|--|
| ☐ Temporary Total Disability Compensation | ☐ Medical & Hospital Benefits |
| ☐ Temporary Partial Disability Compensation | ☐ Vocational Rehabilitation |
| ☐ Permanent Partial Disability Compensation | ☐ Dependency Benefits (Fatal Claim) |
| ☐ Permanent Total Disability Compensation | ☐ Attorney's Fees |

Please attach supporting evidence

If represented:

Attorney _____ Law Firm _____
 Representing ☐ Employee ☐ Employer

 Please print requesting party name

 Signature of Requesting Party

 Date