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
- ☐ Temporary Partial Disability Compensation
- ☐ Permanent Partial Disability Compensation
- ☐ Permanent Total Disability Compensation
- ☐ Medical & Hospital Benefits
- ☐ Vocational Rehabilitation
- ☐ Dependency Benefits (Fatal Claim)
- ☐ 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