

PETITION TO DETERMINE COMPENSATION DUE TO INJURED EMPLOYEE

To the Industrial Accident Board of the State of Delaware

Sitting in and for _____ County

_____	}	Claimant SS# _____
Claimant		Date of Birth _____
vs.		Insurance Carrier _____
_____		OWC Case File No. _____
Employer		

The undersigned petitioner respectfully represents:

That the above named claimant and the above named employer have failed to reach an agreement in regard to compensation due said claimant as an employee of said employer.

The undersigned therefore prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law and state its conclusions of fact and rulings of law.

My signature on this petition is authorization for any doctor, hospital, other health care provider, or State of Delaware Division of Vocational Rehabilitation to supply any and all medical records and reports to the bearer of the original or a copy of this petition regarding any medical condition provided all requests for this information are in writing.

Dated this _____ day of _____, 20____

Claimant's Signature

Name of Attorney, if applicable _____

**INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE**

Statement of Facts Upon Failure to Reach an Agreement

1. Name of Employee _____
Address _____
City _____ State _____ Zip _____
Telephone Number _____ E-mail (optional) _____

2. Date of Accident _____ 3. Place of Accident _____

4. Name of Employer _____
Employer Contact Name _____ E-mail (optional) _____
Address _____
City _____ State _____ Zip _____
Telephone Number _____ Fax# _____

5. Name of Insurance Carrier/ 3rd Party Administrator _____

6. Occupation of employee at the time of accident _____

7. Describe accident/illness and how it happened _____

8. List the body part(s)/illness _____

9. Did employee receive medical, surgical or hospital service? Yes ___ No ___

10. When was notice of injury given to or received by employer? _____

11. Give names and addresses of all employers for the last 5 years. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

12. State weekly wage when injured _____

13. State names and addresses of all treating doctors for this claim. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

14. State names and address of all other treating doctors for the last 10 years. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

15. Give names and addresses and dates of treatment of all hospitals and institutes treating you for this injury. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

16. To what extent did injury prevent employee from working and for how long _____

17. State whether or not employee has fully recovered and if only partially to what extent _____

18. If employee has resumed work, state
 a) when and give name of present employer _____

 b) what trade or occupation and weekly wages _____

19. Identify, give description and dates of all previous and subsequent injuries.

20. State any other important facts bearing on the case above presented _____

I swear or affirm that the information contained in this statement is true and correct to the best of my knowledge and recollection. I understand and acknowledge that any falsehood contained in this statement may expose me to civil or criminal liability.

Dated: _____ Day of _____, 20____

 Employee Signature