

HEARING APPLICATION

Please Read Instructions.

Provision of your Social Security Number (SSN) is mandatory under Section 111 of Medicare, Medicaid and SCHIP Extension Act 2007 (42 U.S.C. s. 1395y (b) (7) & (8)) and will be used to identify the claimant. Failure to provide it may result in penalties and delayed payment of benefits.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Litigated Fax: (608) 260-3053
<https://dwd.wisconsin.gov/wc>

1. Employee Name, Address, City, State, Zip Code		2. Employer Name, Address, City, State, Zip Code (At Time Of Injury)		3. WC Insurance Carrier Name, Address, City, State, Zip Code	
				3a. Insurance Carrier Telephone No. (Area Code)	
				3b. Date of Injury (Mo/Day/Yr)	
1a. Employee Social Security No.		2a. Federal Employer Identification Number (If Known)		3c. Last Date Employee Worked Before Disability	
1b. Employee Telephone No. (Include Area Code)		2b. Employer Telephone No. (Include Area Code)		3d. Date Notice of Injury Given to Employer	
1c. Date of Birth (Mo/Day/Yr)	Sex M F	2c. Nature of Employer Business		4. Have You Applied for or are You Receiving Social Security Benefits? Yes No	
1d. Employee Attorney (if any) Name & Full Address		2d. Employee Occupation When Injured		4a. Have You Applied for or are You Covered Under Medicare? Yes No If Yes, Medicare Claim Number:	
		2e. Employee Gross Weekly Wage When Injured			
Answer Questions 5 To 5c If Claim Is Made For Death Benefit					
1e. Is the Certification of Readiness included with this Application? Yes No		5. Name of Deceased and Date of Death		5a. Are You a Dependent of the Deceased? Yes No	
1f. Attorney's Telephone No. (Include Area Code)		5b. Applicant's Relation to Deceased Husband Wife Child Other		5c. Did You Live with the Deceased? Yes No	
6. How did the Injury or Death Occur? If Possible, Specify if Single Event or Long-Term Exposure.			6a. Describe Parts of the Body Affected.		
7. Check the Boxes Below for which Compensation is being Sought and Specify Detail, if known:					
7a. Temporary Total Disability (Month/Day/Year)					
From		To		From	
				To	
7b. Temporary Partial Disability			7c. Transportation Costs (Mileage)		
From		To			
7d. Permanent Partial Disability % of Body Part			7e. Permanent Total Disability Starting Date		
7f. Medical Expense Denied \$ Has Treatment Ended? Yes No			7g. Penalty		7h. Other
8. Names of Medical Practitioners who Treated Applicant:				9. Is the Employee Working Now? Yes No	
10. Were Medical Expenses Paid Yes No If Yes, By Whom?			11. Are You Currently Receiving Worker's Compensation Disability Benefits? Yes No		
12. Have Sickness and Accident Benefits/Income Continuation been Paid for Lost Wages? Yes No			12a. If Yes, Indicate by whom and the Amounts		
13. I will be Ready for a Formal Hearing in: Due Course. Due Course but not before this Date			14. I Request the Hearing be Scheduled at the Wisconsin City shown here:		
15. _____ 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			16. FOR OFFICE USE ONLY: HR PT NR Issues _____ <input type="checkbox"/> GL35 <input type="checkbox"/> GL35A <input type="checkbox"/> GL48 Length _____ <input type="checkbox"/> GL33 <input type="checkbox"/> GL70 <input type="checkbox"/> GL34 Date _____ <input type="checkbox"/> GL33A <input type="checkbox"/> GL39 <input type="checkbox"/> GL31		