



Claimant's Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Carrier: \_\_\_\_\_  
Preparer's Name: \_\_\_\_\_ Preparer's Phone #: \_\_\_\_\_

**A claim for workers' compensation benefits is made based on the following grounds:**

Injury  Illness  Repetitive Trauma

1. Compensation Rate: \_\_\_\_\_ 2. AWW: \$ \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_
3. Type of injury and body part(s): \_\_\_\_\_
4. Facts in controversy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Legal issues involved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Unusual aspects: \_\_\_\_\_
7. Witnesses (designate if expert):\* \_\_\_\_\_  
\_\_\_\_\_
8. Exhibits: \_\_\_\_\_  
\_\_\_\_\_
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):  
\_\_\_\_\_  
\_\_\_\_\_
10. Name, address, and specialty, if any, of the treating physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Impairment rating(s); body part(s); physician and date of opinion: \_\_\_\_\_
12. I am amending my Form 50/51 in the following manner: \_\_\_\_\_  
\_\_\_\_\_

**I verify the contents of this form are accurate and true to the best of my knowledge.**

Signature: \_\_\_\_\_ Email: \_\_\_\_\_

Date of hearing: \_\_\_\_\_ Time needed for hearing: \_\_\_\_\_

On behalf of  Claimant  Employer

File this form and proof of service on the opposing party according to R.67-611. Do not send medical reports.

\* Commissioners reserve the right to admit expert witnesses at hearings.