Ohio | Industrial Commission

Claim Number:

# NOTICE OF APPEAL

| Injured Worker Information | | Employer Information | |
|---|---|---|---|
| Name | | Name | |
| Address | | Address | |
| City, State, Zip | | City, State, Zip | |
| Telephone | Fax | Telephone | Fax |
| **Injured Worker's Representative Information** | | **Employer's Representative Information** | |
| Rep ID# | | Rep ID# | |
| Name | | Name | |
| Telephone | Fax | Telephone | Fax |

Appealed by:

☐ Injured Worker
☐ Employer
☐ BWC Administrator

Appealing Order of:

☐ BWC Administrator
☐ District Hearing Officer
☐ Staff Hearing Officer

Hearing Location _____ (city)

Heard on _____ (mm/dd/yyyy)

Date Order Received _____ (mm/dd/yyyy)

NOTE: If you are filing an appeal of a staff hearing officer order, failure to identify the necessary documents may result in a determination not to hear an appeal at the Commission level.

REASON FOR APPEAL: _____

Have you filed, or do you intend to file, new evidence not available at the last hearing? ☐ Yes ☐ No

To be completed by Self-Insuring Employer.
☐ Compensation / benefits HAVE or WILL be timely paid as mandated by R.C. 4123.511
☐ Compensation / benefits WILL NOT be timely paid as mandated by R.C. 4123.511

☐ I will be requesting an interpreter for the upcoming hearing. Language Needed: _____
☐ I will be requesting a court reporter.
By checking either or both boxes, I am asking for extra time for the hearing.

I hereby certify that I have mailed copies of this notice to the ☐ injured worker's representative and/or ☐ employer's representative (check one or both), on _____ mm/dd/yyyy

If there is no representative, I have mailed a copy to the injured worker and/or employer.

☐ By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this notice of appeal by the ☐ Injured Worker ☐ Employer.

_____ (Appellant's Signature)