HEARING APPLICATION

Please read instructions on top sheet.

Press hard - you are making 4 copies

Department of Workforce Development
Worker's Compensation Division
P.O. Box 7901, Madison, WI 53707-7901
(608) 266-1340 or 266-1341
Deaf, hearing or speech impaired callers may reach us through WI TRS.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 5.04(l)(m)].

1. Employe's Name, Address, City, State, Zip	2. Employer's Name, Address, City, State, Zip (At Time of Injury)	3. W.C. Insurance Carrier, Address, City, State, Zip
IA. Employe's Social Security No.		
I B. Employe's Telephone No. (include area code) ( )	2A. Employer's Telephone No. (include area code) ( )	3A. Insurance Carrier Telephone No. (area code) ( )
I C. Date of Birth (mo/day/yr) / Sex ☐ M ☐ F	2B. Nature of Employer's Business	3B. Date of Injury (mo/day/yr)
1 D. Employe's Attorney's (if any) Name & Full Address: Douglas J. Phebus, Lawton & Cates, S.C., P.O. Box 2965, Madison, WI 53701-2965	2C. Employe's Occupation When Injured	3C. Last Date Employe Worked Before Disability
	2D. Employe's Gross Weekly Wage When Injured	3D. Date Notice of Injury Given to Employer (mo/day/yr):
	ANSWER QUESTIONS 4 TO 4C IF CLAIM IS MADE FOR DEATH BENEFIT	
	4. Name of Deceased and Date of Death	4B. Are You a Dependent of the Deceased? ☐ Yes ☐ No
1 E. Attorney's Telephone No. (include area code) (608) 282-6200	4A. Relation to Deceased ☐ Husband ☐ Wife ☐ Child ☐ Other	4C. Did You Live With the Deceased? ☐ Yes ☐ No

5. Describe the nature of the disability, parts of the body affected, how the injury or death occurred.

6. Check the boxes below for which compensation is being sought and specify detail, if known:

6A. ☐ Temporary Total Disability (day, month and year) From TO	From TO	
6B. ☐ Temporary Total Disability From TO	6C. ☐ Permanent Total Disability Starting Date:	6D. ☐ Permanent Partial Disability %
6E. ☐ Medical Expenses Denied $	6F. Transportation Costs (mileage, etc.) $	6G. ☐ Other:

7. Names and Addresses of Medical Practitioners Who Treated Applicant:

8. Has Employe Returned to Work?
☐ Yes ☐ No If Yes, On What Date? _____ Did Employe Return to Same Employer? ☐ Yes ☐ No

9. Was Medical Expense Paid? ☐ Yes ☐ No If Yes, By Whom?	1 0. Are You Currently Receiving Worker's Compensation? ☐ Yes ☐ No
I 1. Have Sickness and Accident Benefitslincome Continuation Been Paid for Lost Wages or Medical Expenses? ☐ Yes ☐ No	1 1 A. If Yes, Indicate By Whom and the Amounts.
12. 1 Will Be Ready For A Formal Hearing On or After The Date Indicated Below: Immediately	I Request the Hearing Be Scheduled at the Wisconsin City Shown Below: Madison

13. _____
Employe's 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

15. FOR OFFICE USE ONLY:

HR PT NR

Issues _____ ☐ GL35 ☐ GL35A ☐ GL48

Length _____ ☐ GL33 ☐ GL70 ☐ GL34

Date _____ ☐ GL33A ☐ GL39 ☐ GL31

WKC-7 (R. 11/96)