

W.C.C. # _____



W.C.C. Pending Petitions:

State of Rhode Island Judiciary

Providence, S.C.

Workers' Compensation Court

Petition for Dispute Involving Injured On Duty Claim

PETITIONER:

RESPONDENT:

1. NAME OF INJURED EMPLOYEE	Date of Birth (mm/dd/yyyy)	6. NAME OF EMPLOYER
2. HOME ADDRESS (Street, City or Town, State and Zip Code)		7. BUSINESS ADDRESS (Street, City or Town, State and Zip Code)
3. DESCRIPTION OF EMPLOYEE'S JOB		8a. NAME OF AGENT FOR SERVICE OF PROCESS
4. NATURE OF EMPLOYER'S BUSINESS		8b. ADDRESS OF AGENT FOR SERVICE OF PROCESS
5. DATE OF ALLEGED INJURY (MONTH, DAY, YEAR, TIME)		9. NAME OF EMPLOYER'S INSURANCE CARRIER ON DATE OF ALLEGED INJURY (If Any)
		10. DID INJURY OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No

11. IF NOT ON EMPLOYER'S PREMISES, WHERE DID INJURY OCCUR?

12. NAME(S) AND ADDRESS (ES) OF WITNESS (ES) TO INJURY

13. HOW DID INJURY OCCUR?

14. NATURE OF INJURY AND PARTS OF BODY AFFECTED BY INJURY

15. NAME(S) OF PHYSICIAN(S) AND HOSPITAL(S) WHO HAVE RENDERED SERVICES

16. SALARY OR WAGE AT TIME OF INJURY

17. FIRST DAY OF LOST TIME

18. (a) DID EMPLOYEE RETURN TO WORK FOLLOWING THE INJURY?

(b) IF SO, WHAT DATE?

Yes

No

19. PETITIONER SEEKS A BENEFIT AND/OR DISABILITY DETERMINATION FROM THE COURT AS FOLLOWS:

THE NATURE AND STATUS OF DISABILITY OF THE INJURED EMPLOYEE. (PLEASE SPECIFY DISPUTE):

THE NATURE AND LOCATION OF INJURY RELATIVE TO THE WORK INCIDENT. (PLEASE SPECIFY DISPUTE):

MAXIMUM MEDICAL IMPROVEMENT (MMI) AS DEFINED UNDER §28-29-2(9). (PLEASE STATE BASIS):

ISSUE INVOLVING LEGAL AND/OR MEDICAL CAUSATION. (PLEASE SPECIFY ISSUE):

SUITABLE ALTERNATIVE EMPLOYMENT ISSUES (PLEASE SPECIFY ISSUE):

ENFORCEMENT OF COURT ORDER, DECREE AND/OR CONSENT AGREEMENT (PLEASE STATE DETAILS):

COUNSEL, WITNESS ATTORNEY AND SHERIFF'S FEES AND COSTS ARE SOUGHT PER §28-35-32.

Name of Attorney

Signature of Petitioner

Address and Phone Number of Attorney

Date

Bar Registration Number

Signature of Attorney