WORKERS' COMPENSATION COMMISSION

REQUEST FOR REHEARING

INSTRUCTIONS: This form is to be used by parties to a compensation claim only to request reconsideration of a prior decision of the Commission pursuant to LE §9-726. The Request must be based on an alleged error of law or a mistake of fact and must be filed within 15 days after the decision.

CLAIM NUMBER: _____ CLAIMANT: _____

EMPLOYER: _____

INSURER: _____

The undersigned party to this Workers' Compensation Claim hereby requests a rehearing of the decision dated _____ and as justification states:

REQUESTED BY:

FULL NAME _____ **STREET ADDRESS** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

☐ **CLAIMANT** ☐ **CLAIMANT'S ATTORNEY** ☐ **EMPLOYER/INSURER**

☐ **EMPLOYER/ INSURER ATTORNEY** ☐ **OTHER** _____

A copy of this form with supporting documentation, including Issues, has been sent to the other parties/attorneys to this action.

SIGNATURE _____ **DATE** _____ **TELEPHONE NUMBER** _____

CLICK HERE TO CLEAR THE FORM

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