WORKERS' COMPENSATION COMMISSION

REQUEST FOR ACTION ON FILED ISSUES

This form is to be used only for the actions identified below and is to be submitted without a cover letter.

WCC CLAIM NUMBER:

CLAIMANT'S NAME:

EMPLOYER:

INSURER:

HEALTHCARE PROVIDER:

If hearing has been scheduled: DATE **LOCATION**

SELECT ONLY ONE ACTION:

Withdrawal of issues previously filed (Filing party only).

Dismissal of claim (On behalf of claimant only).

"Set With" scheduling:

REQUIRED ITEMS: List **ALL** claims to be included. **EACH** claim listed **MUST** have Pending Issues **AND** a **SEPARATE** Set-With form (H25R) filed in **EACH** claim.

Change of Venue:
Requestor MUST complete the Location and Date Information above

Requested Location:

Reason for Change:

REQUESTED BY:

Claimant **Claimant'sAttorney** **Employer/Insurer** **Employer/InsurerAttorney** **SIF/UEF**

Healthcare Provider/Attorney

CERTIFICATE OF SERVICE

I hereby certify that on this day of , , service of the foregoing and any attached documentation was made in accordance with COMAR 14.09.01.03 to all parties and their attorneys. Failure to notify opposing counsel prior to the hearing date may result in a penalty or fine to be assessed against a party withdrawing issues.

Address: City: State: Zip Code:

Telephone: Email:

Signature

Full Name