WORKERS' COMPENSATION COMMISSION

REQUEST FOR MODIFICATION

INSTRUCTIONS: This form is to be used by parties to a compensation claim only to request that an Order be reconsidered, reopened or modified pursuant to LE §9-736. Fill out this form completely and submit to the Commission without a cover letter. **This form must be accompanied by Issues (WCC Form H24R).**

CLAIM NUMBER: _____ CLAIMANT: _____

EMPLOYER: _____

INSURER: _____

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

- ☐ The claimant is entitled to additional temporary total benefits.
- ☐ The claimant's permanent disability has increased.
- ☐ The claimant's permanent disability has decreased.
- ☐ Other

***REQUESTED BY*:**

FULL NAME _____ **STREET ADDRESS** _____

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

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

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

A copy of this form with supporting documentation, *including* Issues (H24R), has been sent to the other parties/attorneys to this action.

SIGNATURE _____ **DATE** _____ **PHONE NUMBER** _____

WCC H30R (Rev July 2005)

CLICK HERE TO CLEAR THE FORM

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