PETITION FOR REVIEW

To the Industrial Accident Board of the State of Delaware sitting in and for

_____ County.

_____)	_____	_____	_____	
Employer)	SS #	Carrier File #	OWC Case File #	
)				
vs.)	_____ Carrier/Self-Insurer Name		_____ Name of Adjuster	
_____)	_____	_____	_____	
Claimant.	Date of Injury	Adjuster's Phone #	Adjuster's E-mail, If Applicable	

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for Termination of Benefits, Pursuant to §2347:

☐ Claimant returned to work

☐ Claimant is physically able to return to work

☐ Failure to sign agreement(s) / receipt(s)

☐ Missed employer medical examination (s), pursuant to §2343 (b)

☐ Failure to comply with Board's order for vocational rehabilitation services

☐ Claimant's partial disability has terminated or diminished

☐ Other:

Petition to Order Vocational Rehabilitation, Pursuant to §2353 (a):

☐ To obtain an order requesting the claimant's cooperation with vocational rehabilitation services

Petition for Workers' Compensation Fund, Pursuant to §2327:

☐ Reimbursement from the Workers' Compensation Fund

Dated the _____ day of _____ A.D. 20_____.

_____
Name of Attorney

_____
Address

_____

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