

**Instructions**

- \* Print or type all information.
- \* This form is to be used by the injured worker and employer and/or their authorized representatives to object to the tentative order determining a percentage of permanent partial disability compensation.
- \* This objection should be sent to the local Industrial Commission office.

**INJURED WORKER INFORMATION**

Injured worker name	Claim number
Social Security Number	Date of injury

**NAME AND ADDRESS OF PERSON FILING OBJECTION**

Name		
Address		
City	State	9-digit ZIP Code
Please indicate your status		
<input type="checkbox"/> Injured worker	<input type="checkbox"/> Injured worker representative	<input type="checkbox"/> Employer
		<input type="checkbox"/> Employer representative

**INFORMATION FROM TENTATIVE ORDER**

Date of order	Date received
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**ADDITIONAL INFORMATION**

Choose one:  I intend to file additional medical evidence.  I do not intend to file additional medical evidence.

**STATEMENT OF OBJECTION**

*I hereby OBJECT to the TENTATIVE ORDER that determined the percentage of permanent partial disability compensation in the above numbered claim, and request the matter to be set for a hearing before an Industrial Commission district hearing officer.*

*I understand that if this OBJECTION is not received **within twenty days** of the date I received the TENTATIVE ORDER, that order shall become effective and compensation shall be paid as provided in that order.*

**CERTIFICATE OF SERVICE:** I certify that I have served a copy of this objection to the tentative order determining a percentage of permanent partial disability compensation to the  injured worker's representative and / or  employer's representative (check one or both), on \_\_\_\_\_, 20\_\_\_\_. If there is no representative, I have mailed a copy to the injured worker and / or employer.

**By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this objection by the  injured worker  employer.**

Signature	Date
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