Ohio | Industrial Commission

Claim Number:

NOTICE OF APPEAL

Injured Worker Information		Employer Information	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Telephone	Fax	Telephone	Fax
Injured Worker's Representative Information		**Employer's Representative Information**	
Rep ID#		Rep ID#	
Name		Name	
Telephone	Fax	Telephone	Fax

Appealed by:

- ☐ Injured Worker
- ☐ Employer
- ☐ BWC Administrator

Appealing Order of:

- ☐ BWC Administrator
- ☐ District Hearing Officer
- ☐ Staff Hearing Officer

Hearing Location ________ (city)

Heard on ________ (mm/dd/yyyy)

Date Order Received ________ (mm/dd/yyyy)

NOTE: If you are filing an appeal of a staff hearing officer order, failure to identify the necessary documents may result in a determination not to hear an appeal at the Commission level.

REASON FOR APPEAL: ____________________

Have you filed, or do you intend to file, new evidence not available at the last hearing? ☐ Yes ☐ No

To be completed by Self-Insuring Employer.

☐ Compensation / benefits HAVE or WILL be timely paid as mandated by R.C. 4123.511

☐ Compensation / benefits WILL NOT be timely paid as mandated by R.C. 4123.511

☐ I will be requesting an interpreter for the upcoming hearing. Language Needed: ________

☐ I will be requesting a court reporter.

By checking either or both boxes, I am asking for extra time for the hearing.

I hereby certify that I have mailed copies of this notice to the ☐ injured worker's representative and/or ☐ employer's representative (check one or both), on ________ mm/dd/yyyy

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 notice of appeal by the ☐ Injured Worker ☐ Employer.

________ (Appellant's Signature)