IC-88 Ohio Industrial Commission

Application For Permanent Partial Reconsideration

☐ **Address on reconsideration is new**

This form should be delivered to the office where this decision took place.	**CLAIM NUMBER** _____ **SOCIAL SECURITY #**_____ **DATE OF INJURY**_____

This form is to be used by an injured worker or employer in making application for reconsideration of decisions of District Hearing Officers regarding extent of permanent partial disability as provided in O.R.C. 4123.57 (A).

Injured Worker's Address		**Employer's Address**	
Name	Phone ( )	Name	Phone ( )
Address		Address	
City, State, Zip Code	County	City, State, Zip Code	County
Injured Worker's Representative		**Employer's Representative**	
Name		Name	

Appealed by

☐ **BWC Administrator**

☐ **Injured Worker**

☐ **Employer**

Heard at (City)_____

Date of Hearing _____

Date Order Received _____

Applicant states that above numbered claim was heard and the following finding made:

Applicant requests that such finding be reviewed and reconsidered by the Staff Hearing Officer and that the finding be modified in the following respects:

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 _____,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 application for reconsideration by the ☐ injured Worker ☐ Employer

_____

(APPELLANT'S SIGNATURE)