Ohio | Industrial Commission

Objection to Tentative Order

Determining the Percentage of Permanent Partial Disability Compensation

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 permanant 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
☐ Injured worker ☐ Injured worker representative ☐ Employer ☐ Employer representative

INFORMATION FROM TENTATIVE ORDER

Date of order	Date received

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