Reset

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
WORKERS' COMPENSATION DIVISION
PO Box 64620
St. Paul, MN 55164-0620
(651) 361-7900

NO0016

DO NOT USE THIS SPACE

WID or SSN
DATE(S) OF CLAIMED INJURY

EMPLOYEE
VS.
EMPLOYER(S)
AND
INSURER (S)
AND

Notice of Appeal to Workers' Compensation Court of Appeals

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE ABOVE-NAMED PARTIES AND THEIR ATTORNEYS, PLEASE TAKE NOTICE:

That the above-named party, _____, appeals to the Workers' Compensation Court of Appeals from the decision of Compensation Judge _____ dated the _____ day of _____, 20 _____, and the following issues are raised in this Notice of Appeal:

_____

_____

_____

Further, that the specific findings and orders appealed from are numbered in the decision as follows: _____ _____ (give numbers only). If there are other grounds which cannot be raised by reference to the findings, attach an explanation. (See Minn. Stat. § 176.421.)

DATE SIGNED	SIGNATURE OF PERSON FILING APPEAL	
	PRINTED NAME AND TITLE	
	ADDRESS	
	CITY STATE ZIP CODE	TELEPHONE

IMPORTANT: The notice of appeal must be served upon each adverse party, and the original, with proof of service, filed with the Office of Administrative Hearings, together with a $25 filing fee payable to the State Treasurer/OAH. This notice must be served and the original notice and filing fee received by OAH within 30 days after notice of the Judge's decision has been served by the Office of Administrative Hearings.

WID or SSN
DATE(S) OF CLAIMED INJURY

STATE OF MINNESOTA }
} ss.
COUNTY OF _____ }

AFFIDAVIT OF SERVICE

_____, being first duly sworn, says that on _____, (s)he deposited a true and correct copy of the original **NOTICE OF APPEAL TO WORKERS' COMPENSATION COURT OF APPEALS** in the United States Mail in the City of _____, postage prepaid, duly enveloped and stamped, addressed to:

(List opposing attorneys and parties not represented by an attorney with their addresses).

Employee:	Employee Attorney:
Employer:	Employer/Insurer Attorney:
Insurer:	Other Party (Specify):
Other Party (Specify):	Commissioner of Labor and Industry State of Minnesota Department of Labor and Industry PO Box 64221 St. Paul, MN 55164-0218

FILED WITH:
Office of Administrative Hearings
Workers' Compensation Section
PO Box 64620
St. Paul, Minnesota 55164-0620

Subscribed and sworn to before me
this _____ day of _____
Notary Public _____
My Commission expires _____

_____
Signature