

WID NUMBER or SSN
DATE(S) OF CLAIMED INJURY

Court of Administrative Hearings
Workers' Compensation Division
P.O. Box 64620, St. Paul, MN 55164-0620
651-361-7900
PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT



DO NOT USE THIS SPACE

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

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 the Court of Administrative Hearings (CAH) and the Department of Labor and Industry 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 Workers' Compensation Court of Appeals; the departments of Revenue and Health; and the Workers' Compensation Reinsurance Association.

TO THE COURT OF ADMINISTRATIVE HEARINGS

The Employee above named, for his/her petition, alleges the following as facts:

1. That his/her address is _____
2. That the address of the employer is _____
3. That on the date or dates indicated above he/she sustained a personal injury or occupational disease.
4. That on the date or dates he/she was employed by the above employer.
5. That his/her weekly wage at the time of said alleged injury or disease was _____
6. That said injury or disease arose out of and in the course of said employment.
7. That the nature of the injury or disease was as follows: _____
8. That the employer had knowledge or notice of the occurrence of the injury, disease and/or death alleged in paragraph 3.
9. That on the date or dates indicated above the employer was insured against compensation liability by the insurer or insurers indicated above.
10. That said employer and insurer are liable for the following:

DISABILITY BENEFITS

- a. Temporary Total from _____ to _____
- b. Temporary Partial from _____ to _____
- c. Permanent Total from _____ to _____
- d. Permanent Partial % _____ (Applicable PPD rule citation)

MEDICAL BENEFITS

Doctor / Hospital / Other	Amount
e. _____	\$ _____
f. _____	\$ _____
g. _____	\$ _____

REHABILITATION BENEFITS

- h. Describe _____

OTHER

- i. Describe _____

11. NAME and ADDRESS of any third party who has paid disability or medical benefits or income maintenance related to this claim	AMOUNT	CLAIM NUMBER or POLICY NUMBER
12. That employee's date of birth is _____		

The Employee petitions for an award against the Employer and Insurer for such benefits as provided for by the Workers' Compensation Law of Minnesota.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #		TELEPHONE

TRIAL DATA:

Request is made for a settlement conference. Yes No Estimated hours to present evidence: _____

Requested place of: Pretrial _____ Trial _____

Number of Witnesses: _____ (Attach names and addresses) An Affidavit of Significant Financial Hardship is attached. Yes No

If an interpreter is requested for a hearing or conference, specify the language/dialect: _____

If a reasonable accommodation of disability is requested for a hearing or conference, describe: _____

STATE OF MINNESOTA }
 }
COUNTY OF }
 } ss.

AFFIDAVIT OF SERVICE

I, _____, being first duly sworn, state that on _____, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at _____, Minnesota, addressed as follows:

NAMES AND ADDRESSES

Subscribed and sworn to before me

this _____ day of _____

Signature

Notary Public _____

My Commission expires _____

INSTRUCTIONS

1. Failure to properly and fully fill out the claim petition, with appropriate documentation, in accordance with workers' compensation rules of practice, shall not be considered proper filing under Minn. Stat. § 176.291 and 176.305. The Court of Administrative Hearings may refuse to accept a claim petition that lacks any of the following: employee's name, date of injury, WID number or Social Security number, or name of employer/insurer.
2. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
3. If you have more defendants or more injuries than can be listed on the claim petition, it may be modified accordingly.
4. A doctor's report supporting the claim MUST be filed with the claim petition.
5. If additional space is required to list all medical benefits claimed, or to list the names, addresses, etc., of third parties making payment of medical expenses or disability benefits, or there are other issues you wish to include on the petition, attach a separate sheet containing such information to each copy of the petition.
6. If no third party has made payment of any disability, rehabilitation or medical benefits, enter the word "NONE" in the space provided for the name and address in #11.
7. If the employee has fewer than three days of lost time from work, attach a copy of the First Report of Injury, unless one has already been filed.
8. The petitioner must serve a copy of the petition on EACH adverse party (employer(s), insurer(s), the Special Compensation Fund, if applicable, and any third party named in #11) by first class mail or personally.

This material can be made available in different forms, such as large print, Braille or audio. To request, call 651-284-5032 or 800-342-5354.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.