

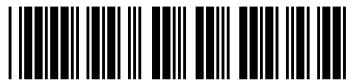
Court of Administrative Hearings  
P.O. Box 64620  
St. Paul, MN 55164-0620

OR\*

Department of Labor and Industry  
P.O. Box 64221  
St. Paul, MN 55164-0221

**State of Minnesota  
Court of Administrative Hearings**

\*Note: Motions to Intervene must be filed with the Court of Administrative Hearings unless applicant intends to intervene in an administrative conference that is pending at the Department of Labor and Industry.



M00001

DO NOT USE THIS SPACE

WID number	
Date(s) of claimed injury	
Employee	vs.
Employer(s)	and
Insurer(s)	and

**Motion to Intervene**

Print in ink or type.  
Enter dates in MM/DD/YYYY format.

1. The applicant is filing this Motion to Intervene in the following disputes(s):

Claim Petition dated \_\_\_\_\_ Rehabilitation Request\* dated \_\_\_\_\_  
Medical Request\* dated \_\_\_\_\_ Request for Formal Hearing dated \_\_\_\_\_

2. The applicant, \_\_\_\_\_ (name of entity filing this Motion to Intervene), has provided services or paid benefits to or on behalf of the employee and has a statutory right to intervene under Minnesota Statutes § 176.361.
3. Attached to this Motion to Intervene is an exhibit(s) itemizing the charges for services provided or payments made to or on behalf of the employee by the applicant from \_\_\_\_\_ (date) to \_\_\_\_\_ (date). The claim to-date is \$\_\_\_\_\_. Upon request of a party or to present evidence of the intervention claim at hearing, the applicant acknowledges it will provide additional documentation, records and reports as required by law.
4. A determination in this case may affect the ability of the applicant to obtain payment from any source for the services provided or payments made to or on behalf of the employee as itemized in the attached exhibit(s).
5. The applicant's representative, who has authority to settle on behalf of the applicant, \_\_\_\_\_ (print name and title), can be contacted at \_\_\_\_\_ (phone number) and \_\_\_\_\_ (email address).
6. Therefore, the applicant requests it be allowed to intervene as a party in the above-captioned proceeding and that payment for services provided or benefits paid be made, plus appropriate statutory interest.

Date signed	Signature of person filing motion		
	Printed name and title		
	Mailing address		Email address
	City	State	ZIP code

WID number
Date(s) of claimed injury

### Proof of service

State of \_\_\_\_\_ }  
 County of \_\_\_\_\_ } ss.

I, \_\_\_\_\_ state that on \_\_\_\_\_ I served a true and correct copy of the attached **Motion to Intervene**, by placing it in a properly stamped and addressed envelope, in the United States mail at \_\_\_\_\_, \_\_\_\_\_, addressed as follows.

Employee	Employee attorney
Employer	Employer/Insurer attorney
Insurer	Other party (specify)
Other party (specify)	Other party (specify)

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Dated \_\_\_\_\_

Signature \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone \_\_\_\_\_