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| --- |
| **Before the Iowa Workers’ Compensation Commissioner** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | , |

|  |  |
| --- | --- |
| File No(s).: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |
|  | Claimant, |  |
|  | vs. |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | , |
|  | Employer, |  | **Hearing Report** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | , |
|  | Insurance Carrier, |  |
|  | Second Injury Fund of Iowa | , |
|  | Defendant(s). |  |

Under Rule 876 IAC 4.19(3)(f), the parties in the above-captioned case jointly submit this Hearing Report, which defines the claims, defenses, and issues submitted to the presiding deputy commissioner.

# Employer-Employee Relationship.

|  |  |
| --- | --- |
|  \_\_\_\_ | 1. The existence of an employer-employee relationship at the time of the alleged injury.
 |

# Injury.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant sustained an injury, which arose out of and in the course of employment, on the following date(s): \_\_\_\_.
 |

# Causation to Disability.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The alleged injury is a cause of temporary disability during a period of recovery.
 |
| \_\_\_\_ | 1. The alleged injury is a cause of permanent disability.
 |

# Entitlement to Temporary Disability and/or Healing Period Benefits.

[ ]  No longer in dispute.

Claimant is seeking either temporary total disability, temporary partial disability, or healing period benefits for the following time period(s): \_\_\_\_.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. If defendant(s) are liable for the alleged injury, claimant is entitled to benefits for this period of time.
 |
| \_\_\_\_ | 1. Although entitlement cannot be stipulated, claimant was off work during this period of time.
 |

# Entitlement to Permanent Partial Disability Benefits.

[ ]  No longer in dispute.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant is entitled to permanent disability benefits for \_\_\_\_ weeks for a \_\_\_\_ % loss of use of the \_\_\_\_ or a \_\_\_\_ % loss of earning capacity.
 |

If the injury is found to be a cause of permanent disability,

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The disability is a scheduled member disability to the \_\_\_\_.
 |
| \_\_\_\_ | 1. The disability is an industrial disability.
 |
| \_\_\_\_ | 1. The commencement date for permanent partial disability benefits, if any are awarded, is \_\_\_\_.
 |

# Rate of Compensation.

At the time of the alleged injury,

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant’s gross earnings were $\_\_\_\_ per week.
 |
| \_\_\_\_ | 1. Claimant was:

[ ]  Married.[ ]  Single. |
| \_\_\_\_ | 1. Claimant was entitled to \_\_\_\_ exemptions.
 |

The parties believe the weekly rate to be $\_\_\_\_ based on the above.

# Affirmative Defenses.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Defense of \_\_\_\_ under Iowa Code section 85.16.
 |
| \_\_\_\_ | 1. Lack of timely notice under Iowa Code section 85.23.
 |
| \_\_\_\_ | 1. Untimely claim under Iowa Code section 85.26.
 |
| \_\_\_\_ | 1. Other: \_\_\_\_
 |

# Medical Benefits.

[ ]  No longer in dispute.

Claimant seeks:

[ ]  Payment of medical expenses. An itemized list of medical expenses is in \_\_\_\_ Exhibit(s) \_\_\_\_.

[ ]  Independent medical examination (IME) under Iowa Code section 85.39.

[ ]  Alternate care under Iowa Code section 85.27.

With reference to the disputed medical expenses:

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The fees or prices charged by providers are fair and reasonable.
 |
| \_\_\_\_ | 1. The treatment was reasonable and necessary.
 |
| \_\_\_\_ | 1. Although disputed, the medical providers would testify as to the reasonableness of their fees and/or treatment set forth in the listed expenses and defendants are not offering contrary evidence.
 |
| \_\_\_\_ | 1. The listed expenses are causally connected to the work injury.
 |
| \_\_\_\_ | 1. Although causal connection of the expenses to a work injury cannot be stipulated, the listed expenses are at least causally connected to the medical condition(s) upon which the claim of injury is based.
 |
| \_\_\_\_ | 1. The requested expenses were authorized by defendant(s).
 |

# Credits Against Any Award.

[ ]  No longer in dispute.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Prior to hearing, claimant was paid \_\_\_\_ weeks of compensation at the rate of $\_\_\_\_ per week.
 |
| \_\_\_\_ | 1. Defendant(s) are entitled to credit under Iowa Code section 85.38(2) for payment of:

[ ]  Sick pay/disability income in the amount of $\_\_\_\_.[ ]  Medical/hospitalization expenses in the amount of $\_\_\_\_ . |

# Second Injury Fund (SIF).

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant sustained a prior qualifying loss to the \_\_\_\_ on \_\_\_\_.
 |
| \_\_\_\_ | 1. The functional loss from the prior qualifying loss is of \_\_\_\_ % of the \_\_\_\_ .
 |
| \_\_\_\_ | 1. Claimant sustained a compensable loss to the \_\_\_\_ on \_\_\_\_.
 |
| \_\_\_\_ | 1. The functional loss from the second qualifying loss is \_\_\_\_ % to the \_\_\_\_ .
 |
| \_\_\_\_ | 1. Claimant believes the commencement date of SIF benefits, if any are awarded, is \_\_\_\_.

If disputed, SIF believes the commencement date for PPD benefits, if any are awarded, is \_\_\_\_.  |
| \_\_\_\_ | 1. SIF is entitled to credit under Iowa Code section 85.64 for \_\_\_\_.
 |

# Additional Issues, Stipulations, and/or Explanation.

Click here to add additional issues, stipulations, and/or explanation

# Disputed Costs.

[ ]  Claimant wishes specific taxation of costs in the decision. An itemized list of costs and proof of payment is in \_\_\_\_ Exhibit(s) \_\_\_\_.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The costs listed in \_\_\_\_ Exhibit(s) \_\_\_\_ have been paid.
 |

# Agreement and Signatures.

The parties agree that the hearing report fully and accurately defines the claims, defenses, and issues submitted to the presiding deputy commissioner.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Attorney for Claimant |  | Signature of Attorney for \_\_\_\_ |
| Name: | \_\_\_\_ |  | Name: | \_\_\_\_ |
| Date: | \_\_\_\_ |  | Date: | \_\_\_\_ |
|  |  |  |  |
| Signature of Attorney for \_\_\_\_ |  |  |  |
| Name: | \_\_\_\_ |  |  |  |
| Date: | \_\_\_\_ |  |  |  |