BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Respondent(s).	No(s).: _____ _____ **Original Notice** *&* **Petition**

ATTENTION:

- You are notified that an action has been commenced with the Iowa Division of Workers' Compensation (DWC) seeking relief as detailed in the petition below.
- You must file with DWC an answer or otherwise respond within 20 days of receipt of this document. If you do not, DWC may enter judgment by default against you for the relief demanded in the petition or impose sanctions under Iowa Administrative Code rule 876—4.36.
- You are advised to seek legal advice at once to protect your interests. If applicable, you should promptly notify your workers' compensation insurance carrier.

PETITION

☐ Arbitration (Iowa Code § 10A.317)
☐ Review-Reopening (Iowa Code § 10A.317)
☐ Medical Benefits (Iowa Code § 85.27)
☐ Death Benefits (Iowa Code §§ 85.28, 85.29, 85.31)
☐ Dependency (Iowa Code §§ 85.42, 85.43, 85.44)
☐ Equitable Apportionment (Iowa Code § 85.43)
☐ Second Injury Fund (Iowa Code § 85.63 *et seq.*)
☐ Other (See Attached)

1. Employer's address: _____
2. Insurance carrier's address: _____
3. Date(s) of injury: _____
4. How injury occurred: _____
5. Injury occurred in city, county, and state of: _____
6. Body part(s) or system(s) affected or disabled:
   - ☐ Eye(s): _____ ☐ Hand(s): _____ ☐ Toe(s): _____
   - ☐ Arm(s): _____ ☐ Foot/Feet: _____ ☐ Finger(s): _____
   - ☐ Leg(s): _____ ☐ Shoulder(s): _____ ☐ Thumb(s): _____
   - ☐ Permanent disfigurement of the face or head ☐ Hearing in ear(s): _____
   - ☐ Body as a Whole: _____
   - ☐ Other: _____
7. Time period(s) disabled: _____

8. The dispute in this case includes:

☐ Rate(s) ☐ Causation ☐ Nature and extent of disability

☐ Interest ☐ Alternate Care ☐ Medical expenses

☐ Mileage ☐ Penalty ☐ Reimbursement for independent medical examination

☐ Entitlement to benefits for: _____

☐ Other: _____

9. Petitioner requests respondent(s) agree a hearing may be held in Iowa Judicial District: _____

10. Second Injury Fund benefits are sought for the loss described above and the following first loss:

    a. Date: _____

    b. Member: _____

    c. How member affected: _____

11. Death benefits are sought for:

    a. Full name of deceased employee: _____

    b. Date of deceased employee's death: _____

    c. Deceased employee's relationship to petitioner(s): _____

    d. Funeral expenses: _____

    e. Dependent(s) and relationship(s) to deceased employee: _____

Petitioner hereby incorporates the statutory provisions applicable to the relief sought, prays the agency grant the relief sought and schedule a hearing, and requests respondent(s) respond or incur sanctions under Iowa Administrative Code rule 876—4.36.

Signature of Attorney for Petitioner – *or* – Self-Represented Petitioner

Full Name: _____

Law Firm: _____

Telephone: _____

Email: _____

Mailing Address: _____