

PETITION TO REVIEW

To the Industrial Accident Board of the State of Delaware sitting in and for
_____ County.

_____ Employer,) _____ SS#	_____ OWC Case File #	_____ Case File #
vs.) _____ Carrier/Self-Insurer Name	_____ Name of Adjuster	
_____ Claimant.) _____ Date of Injury	_____ Adjuster's Phone #	_____ Adjuster's Email, if Applicable

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for Termination of Benefits, Pursuant to §2347:*

*By checking below Fund benefits will be issued upon receipt of completed ECF- N/A Self-Insured (L)

_____ Claimant is physically able to return to work
_____ Claimant's partial disability has terminated or diminished

Petition for Termination of Benefits:

_____ Claimant returned to work
_____ Failure to sign agreement(s) / receipt(s)
_____ Missed employer medical examination (s), pursuant to §2343 (b)
_____ Failure to comply with Board's order for vocational rehabilitation services
_____ Other: _____

Petition to Order Vocational Rehabilitation, Pursuant to §2353 (a):

_____ To obtain an order requesting the claimant's cooperation with vocational rehabilitation services

Petition for Workers' Compensation Fund, Pursuant to §2327:

_____ Reimbursement from the Workers' Compensation Fund

Dated the _____ day of _____ 20_____.

Name of Claimant's Attorney (If known)

Name of Employer's Attorney

Address

Address

****NOTE**:** No Petition to Review shall be accepted by the Department, **unless** it is accompanied by adequate proof of service (**Pursuant to §2347**) that a copy of the Petition to Review has been served upon the other party to the agreement or award.