PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE TO INJURED EMPLOYEE

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

_____ County.

_____ Claimant	)	_____ SS#	_____ Carrier File #
vs.	)	_____ Carrier/ Self-Insurer Name	
_____ Employer	)	_____ Date of Injury	_____ OWC Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all partied 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 additional compensation due - Please check the appropriate block(s):

☐ Recurrence of the total disability benefits, pursuant to §2324 for the period(s) _____

_____

☐ Recurrence of partial disability benefits, pursuant to §2325 for the period(s) _____

_____

☐ Permanent impairment, pursuant to §2326.*

Permanency Percentage:				
Part of Body:				
Dr. who rated permanency:				

☐ Transportation expenses

☐ Medical expenses/bills, other than appeals for a utilization review determination. Use the DACD petition dedicated for utilization review determination appeals for those medical expenses.

☐ Other _____

My signature on this Petition is authorization for any doctor, hospital, other health care provider, or State of Delaware Division of Vocational Rehabilitation to supply any and all medical records and reports to the bearer of the original or a copy of this petition regarding any medical condition provided all requests for this information are in writing.

Dated this _____ day of _____ 20_____

_____
Claimant's Signature or Counsel for Claimant

_____
Address

_____
City, State, and Zip Code

_____
Phone Number

_____
Name of Employer's Attorney

Revised: 03/17/2023

***Permanency Report Required**