PETITION TO DETERMINE COMPENSATION DUE TO INJURED EMPLOYEE

To the Industrial Accident Board of the State of Delaware

Sitting in and for ___________________ County

		Claimant SS# ____________________
______________________________________ Claimant	}	Date of Birth ____________________
vs.		Insurance Carrier ____________________
______________________________________ Employer		Case File No. ____________________

The undersigned petitioner respectfully represents:

That the above named claimant and the above named employer have failed to reach an agreement in regard to compensation due said claimant as an employee of said employer.

The undersigned therefore 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.

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 ____________________A.D. 20____

____

Claimant's Signature

Name of Attorney, if applicable ____

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INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

Statement of Facts Upon Failure to Reach an Agreement

1. Name of Employee ______________________________

   Address ______________________________

   City______________________ State____________ Zip ____________

   Telephone Number ______________E-mail (optional) ______________

2. Date of Accident ____________ 3. Place of Accident ______________________

4. Name of Employer ______________________________

   Employer Contact Name________________ E-mail (optional) ____________

   Address ______________________________

   City______________________ State ____________ Zip ____________

   Telephone Number ______________Fax # ______________________

5. Name of Insurance Carrier / 3rd Party Administrator ______________________

6. Occupation of employee at the time of accident ______________________

7. Describe accident/illness and how it happened ______________________

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8. List the body part(s)/illness ______________________________

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9. Did employee receive medical, surgical or hospital service? ☐Yes ☐No

10. When was notice of injury given to or received by employer? ______________

11. Give names and addresses of all employers for the last 5 years. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

12. State weekly wage when injured ______________________

13. State names and addresses of all treating doctors for this claim. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

14. State names and address of all other treating doctors for the last 10 years. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

15. Give names and addresses and dates of treatment of all hospitals and institutes treating you for this injury. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

16. To what extent did injury prevent employee from working and for how long ________________

____

17. State whether or not employee has fully recovered and if only partially to what extent _________

____

18. If employee has resumed work, state

a) when and give name of present employer ________________________________

____

b) what trade or occupation and weekly wages ________________________________

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19. Identify, give description and dates of all previous and subsequent injuries.

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20. State any other important facts bearing on the case above presented ________________

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I swear or affirm that the information contained in this statement is true and correct to the best of my knowledge and recollection. I understand and acknowledge that any falsehood contained in this statement may expose me to civil or criminal liability.

Dated: _______ Day of _____________, 20____

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Employee Signature