WORKERS' COMPENSATION COMMISSION

REQUEST FOR ACTION ON FILED ISSUES

This form is to be used only for the actions identified below and is to be submitted without a cover letter.

WCC CLAIM NUMBER: _____

CLAIMANT'S NAME: _____

EMPLOYER: _____

INSURER: _____

If hearing has been scheduled: DATE _____ LOCATION _____

SELECT ONLY ONE ACTION:

◯ Withdrawal of issues previously filed (Filing party only).

◯ Dismissal of claim (On behalf of claimant only).

◯ "Set With" scheduling:
The following numbered claim(s) have pending issues and should be set with this claim when it is scheduled for hearing:

◯ Change of Venue:
Requestor MUST complete the Location and Date Information above

Requested Location:

Reason for Change:

REQUESTED BY:

◯ Claimant ◯ Claimant'sAttorney ◯ Employer/Insurer ◯ Employer/InsurerAttorney ◯ SIF/UEF

CERTIFICATION OF SERVICE

I hereby certify that on this _____ day of _____, _____ , a copy of this Request and any attached documentation was mailed to all parties and their attorneys. Failure to notify opposing counsel prior to the hearing date may result in a penalty or fine to be assessed against a party withdrawing issues.

_____ _____

Name Signature

Telephone Number _____

WCC Form H25R (February 2007)

10 East Baltimore Street • Baltimore, MD 21202-1641
410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us