

# REQUEST THAT CLAIM BE ASSIGNED FOR HEARING

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act.

Employee's Name (LAST NAME) (FIRST NAME)		Employer's Name ( )		Telephone Number	
Address		Employer's Address		City	State Zip
City	State Zip	Insurance Carrier			
( )	( )	Carrier's Address		City	State Zip
Home Telephone	Work Telephone	( )		( )	
Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Carrier's Telephone Number	Fax Number	

Date of injury: \_\_\_\_\_ Part of body: \_\_\_\_\_

City and county where the injury occurred: \_\_\_\_\_

Estimated length of hearing: \_\_\_\_\_

This case will be set in the county where the injury occurred unless otherwise authorized by the Commission. If the requesting party wants the hearing to be set in a different county, name the county below and the reason for that location.

(County) \_\_\_\_\_ (Reason for setting) \_\_\_\_\_

I, \_\_\_\_\_,  Plaintiff/Attorney  Defendant/Attorney, respectfully notify you that the above named parties have failed to reach an agreement regarding compensation, and I request a hearing.

We have been unable to agree because (State reason with specificity. If appealing an Administrative Order, provide the file date of the Order and the name of the hearing officer who issued the order.):

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Employee believes he or she is entitled to the following workers' compensation benefits (check all that apply):

- Payment of compensation for days missed (give dates): \_\_\_\_\_
- Payment of medical expenses/treatment: \_\_\_\_\_
- Payment for permanent partial disability: \_\_\_\_\_
- Payment for permanent and total disability: \_\_\_\_\_
- Payment for scars: \_\_\_\_\_
- Other: \_\_\_\_\_

Has claimant participated in mediation?  Yes  No

**ATTORNEYS:**  
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL  
[HTTP://WWW.IC.NC.GOV/DOCFILING.HTML](http://www.ic.nc.gov/docfiling.html)

**EMPLOYEE FILING OPTIONS:**  
E-MAIL TO [DOCKETS@IC.NC.GOV](mailto:DOCKETS@IC.NC.GOV)  
FAX TO (919) 715-0282  
MAIL TO NCIC-DOCKET SECTION  
1236 MAIL SERVICE CENTER  
RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349  
WEBSITE: [HTTP://WWW.IC.NC.GOV](http://www.ic.nc.gov)

Below is a list of names of all witnesses, including doctors, whose testimony is to be taken by the requesting party. Addresses must be provided for the doctors listed below.

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby certify that this case is ready for hearing. When a date of hearing is set, I respectfully request the Commission to send me signed subpoenas for my witnesses. When I receive these subpoenas, I will serve them pursuant to the instructions on Page 2 of the Industrial Commission Form 36.

<b>Signature</b> of Party Requesting Hearing Check one: <input type="checkbox"/> Employee, <input type="checkbox"/> Employer; <input type="checkbox"/> Attorney	<b>Printed Name</b> of Party Requesting Hearing
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**Mailing Address:** Street and number, city, state and ZIP Code

**Telephone Number:** \_\_\_\_\_ **Date of Notice:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Notice to Employees: The original of this form must be sent to the Industrial Commission at the address below or by e-mail to [dockets@ic.nc.gov](mailto:dockets@ic.nc.gov). A copy of the form must be sent to opposing parties.**

**CERTIFICATE OF SERVICE**

I hereby certify that on \_\_\_\_\_, I served a copy of this Form 33 Request for Hearing, together with all supporting documents, on the following party(ies) by way of

\_\_\_\_\_  
(U.S. Mail, special delivery mail, e-mail, fax, hand delivery, etc.)

[Note: List name and address of each attorney or party served. Attach a separate sheet if necessary.]

Signature	Printed Name	Date
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