

NOTICE OF AWARD

IC File # _____

Emp. Code # _____

Employer FEIN _____

Carrier File # _____

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

Carrier Code # _____

Employee's Name _____

Employer's Name _____ () Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

() Home Telephone _____ Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

(M) (F) Social Security Number _____ Sex _____ / / Date of Birth _____

() Carrier's Telephone Number _____ () Fax Number _____

The above parties have previously submitted an agreement for compensation for disability or death on Form _____. The Commission entered an award in the case upon receipt of the agreement. The Commission has now been informed that _____

Therefore, the original award is amended as follows:

As above mentioned, said Agreement is hereby approved. This is a formal award of the Industrial Commission. Any interested party may give notice of appeal therefrom within fifteen (15) days or receipt of this award.

SIGNATURE

TITLE

DATE