

NOTICE OF AWARD

IC File # _____

Emp. Code # _____

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 _____			
() _____	() _____	Carrier's Address _____		City _____	State _____ Zip _____
Home Telephone _____	Work Telephone _____	() _____		() _____	
XXX-XX- _____	☐ M ☐ F	Carrier's Telephone Number _____		Fax Number _____	
Last 4 Digits of SSN _____	Sex _____	Date of Birth _____			

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