

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 _____			() _____			() _____		
XXX-XX- _____			Carrier's Telephone Number _____			Fax Number _____		
Last 4 Digits of SSN _____								
☐ M ☐ F								
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