



Instructions

- Please use a typewriter or ballpoint pen and press firmly to complete this form.
• You or your representative must sign this form before submission.
• You must submit one copy and retain one copy for your records.
• If assistance is needed you may contact your local BWC customer service office.

Claim number

Application for:
[ ] Determination of the initial percentage of permanent partial disability (%PPD);
[ ] Determination in the %PPD for a newly allowed condition in this claim (no new medical required);
[ ] Increase in the %PPD - I believe the percentage of permanent partial disability has increased over the percentage previously determined. I have attached three copies of the medical report from my doctor to support this application. Medical reports attached are accompanied by evidence of new and changed circumstances.

Part A - Injured Worker Information

Injured worker name, Social Security number, Date of injury, Address, City, State, Nine-digit ZIP code, County, Work telephone number, Home telephone number

Part B - Application Information

Employer at the time of injury, Telephone number, Address, City, State, Nine-digit ZIP code, Describe the disability you now consider to be permanent as a result of your injury or occupational disease. How does this injury or occupational disease affect your activities of daily living? (specify parts of the body affected), Other workers' compensation claim numbers and the nature of each injury or occupational disease are listed below.

I certify the information on this form is true and correct. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits/compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Part C - Authorization

Name of injured worker representative (if represented) (please print or type), REP I.D. number, Signature of injured worker / injured worker representative (if represented), Date, I hereby authorize the BWC/employer to forward any monetary award generated by this application to the attorney indicated above for disbursement to me., Signature of injured worker, Date

BWC Use Only

Copy mailed to: [ ] Employer [ ] Employer representative, Date mailed

Distribution: Original-Claim file Copies-as needed