

%PPD WORKSHEET/10 YEAR CHECK

Requested wages (V3 Correspondence)

Application for:

The determination of the percentage of permanent partial disability.

Increase in the percentage of permanent partial disability.

Date of filing
Claim number
%PPD previously awarded in this claim

Injured worker name	Social Security Number
County	Date of injury

Specialist exam(s) needed (designate type of specialist or write N/A if none needed)

Review ONLY the body parts (conditions) allowed in this claim. See the description of allowed conditions listed below.

1. Medical exam / examiner / allowed condition(s)

2. Medical exam / examiner / allowed condition(s)

3. Medical exam / examiner / allowed condition(s)

CSS: please note the names of doctors the injured worker has seen within this claim. (Optional)

Claim Number	Date of Injury	Part of Body	% PP

CSS name	Date completed
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