



MOTION

INSTRUCTIONS:

- This form is to be used by the injured worker or employer and/or their authorized representatives to request a decision by the Bureau of Workers' Compensation or the Industrial Commission that cannot be accomplished through any other form or application.
- This form is **NOT TO BE USED BY HEALTH CARE PROVIDERS OR MANAGED CARE ORGANIZATIONS.** Health Care Providers or Managed Care Organizations must use form C-9, *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease.*
- Proof must be submitted with this form.
- The applicant must mail a copy of the Motion to the opposite party and/or their authorized representative and shall indicate that a copy has been mailed by signing Certificate of Service below.

Injured worker name		Claim number	
Street address	City	State	9-digit ZIP Code

This MOTION is a request to consider the following:

In support of this MOTION, the following evidence is included: (identify affidavits, medical records or other documents)

CERTIFICATE OF SERVICE: I certify that I have served a copy of this Motion on all parties and representatives to the claim.

Signed _____ Date signed _____

- Injured worker
 Employer
 Authorized Representative
 CEO/Administrator of Bureau of Workers' Compensation

Distribution: Original – Claim File Copies – as needed