IC-12 The Industrial Commission of Ohio

NOTICE OF APPEAL

This form should be delivered to the office where this decision took place.

CLAIM NUMBER _____

SOCIAL SECURITY # _____

DATE OF INJURY _____

❑ **Address on appeal is new**

Injured Worker's Address		**Employer's Address**	
Name	Phone ( )	Name	
Address		Address	
City, State, Zip Code	County	City, State, Zip Code	Phone ( )
Injured Worker's Representative's		**Employer Representative's**	
Name		Name	

Appealed by ❑ **Injured Worker** ❑ **Employer** ❑ **BWC Administrator**

Appealing Order of

❑ **BWC Administrator**

❑ **District Hearing Officer**

* ❑ **Staff Hearing Officer**

Heard at (City)_____**Oh.**

Date of Hearing:_____

Date Order Received:_____

Reason for Appeal: _____

_____

How would you like the order changed: _____

_____

Have you or do you intend to file new evidence not available at the last hearing?

❑ **Yes** ❑ **No**

To be completed by Self-Insured Employer.

❑**Compensation / benefits timely paid as mandated by R.C. 4123.511**

❑**Compensation / benefits NOT timely paid as mandated by R.C. 4123.511**

* **NOTE: Failure to submit the necessary documents may result in a determination not to hear an appeal at the Commission level.**

I hereby certify that I have mailed copies of this notice to the ❑ injured worker's representative and / or ❑ employer's representative **(check one or both)**, on _____, 20 ___. If there is no representative, I have mailed a copy to the injured worker and/or employer.

❑ By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this appeal by the ❑Injured Worker ❑Employer.

_____

(Appellant's Signature)