Workers' Compensation Board of Review
PO Box 2628
Charleston, WV 25329-2628
(304)558-5230

PETITION ALLEGING EMPLOYER OR ITS CLAIM ADMINISTRATOR HAS FAILED TO TIMELY ACT

CLAIMANT'S NAME: _____ **CLAIM NUMBER** _____

SUBMITTED BY: _____ **DATE OF INJURY** _____

CLAIMANT'S ADDRESS: _____

CLAIMANT'S PHONE #: _____

EMPLOYER: _____

EMPLOYER'S INSURER: _____

WHAT HAVE YOU ASKED EMPLOYER TO DO? (Please attach documentation of requests to this form)

- ☐ **Initial Ruling on New Claim Filed**
- ☐ **Authorize Medical Treatment**
- ☐ **Rule on Reopening Request**
- ☐ **Arrange for a Permanent Partial Disability Evaluation**
- ☐ **Enter an Award Based Upon an Independent Medical Evaluation**
- ☐ **Comply with a Ruling of the Office of Judges, Board of Review, Intermediate Court of Appeals, or WV Supreme Court**
- ☐ **Other (briefly state what you asked for):**

DATE YOU MADE REQUEST TO, OR FILED CLAIM WITH, EMPLOYER: _____

NAME AND ADDRESS TO WHOM YOU SENT OR SUBMITTED REQUEST: _____

_____

_____

DATE _____

cc: _____ Signature: _____

_____

_____

_____