Workers' Compensation Board of Review

PO Box 2628
Charleston, WV 25329-2628
(304)558-5230

PETITION FOR AWARD OF CLAIMANT'S ATTORNEY FEES and COSTS

WV Code §23-5-16(c)

JCN:

CLAIMANT'S NAME:

EMPLOYER:

DATE OF CLAIMS ADMINISTRATOR'S ORDER DENYING MEDICAL BENEFITS:

DATE OF FINAL ORDER Issued by Board of Review:

Submitted by (print claimant's attorney's name):

Bar ID#

Address:

JCN:

CLAIMANT'S NAME:

STATEMENT

Date of service	Description of service	Hours (1/4 hr. increments)

Total hours

Date costs incurred	Description of costs	Amount

Total amount of costs

CERTIFICATE OF SERVICE

I hereby certify that the foregoing petition for attorney fees and costs is true and correct to the best of my knowledge. Further, I certify that the foregoing petition was served upon the claimant, employer, claims administrator, and employer's counsel (if applicable) by placing a true and exact copy thereof in a properly addressed stamped envelope in the United States mail, postage prepaid to the following:

Signature: _____ **Date:**