

\_\_\_\_\_, :  
Claimant, : File No(s). \_\_\_\_\_  
-vs- :  
\_\_\_\_\_, : HEARING REPORT AND  
Defendant Employer, : ORDER APPROVING SAME  
\_\_\_\_\_, :  
 :  
Defendant Insurance Carrier. :  
\_\_\_\_\_

**HEARING REPORT**

(To be jointly submitted at hearing by all parties)

INSTRUCTIONS: Identify disputed issues and stipulations below by encircling either "D" for disputed or "S" for stipulated. Attach an itemized list of exhibits and disputed medical expenses. Additional material may be attached if it will be helpful for clarification of the disputes or stipulations.

Employer-Employee Relationship.

D S The existence of an employer-employee relationship at the time of the alleged injury.

Injury.

D S Claimant sustained an injury on \_\_\_\_\_ which arose out of and in the course of employment.

Causation to Disability.

D S The alleged injury is a cause of temporary disability during a period of recovery.

D S The alleged injury is a cause of permanent disability

TTD/HP Entitlement. If no longer in dispute check here ( ).

Claimant is seeking either temporary total, temporary partial disability or healing period benefits from \_\_\_\_\_ through \_\_\_\_\_ and \_\_\_\_\_

D S If defendant(s) are liable for the alleged injury, claimant is entitled to benefits for this period of time.

D S Although entitlement cannot be stipulated, claimant was off work during this period of time.

PPD Entitlement. If no longer in dispute check here ( ).

D S Claimant is entitled to permanent disability benefits for \_\_\_\_\_ weeks for a \_\_\_\_\_% loss of use of the \_\_\_\_\_ or a \_\_\_\_\_% loss of earning capacity.

If the injury is found to be a cause of permanent disability,

D S the disability is a scheduled member disability to the \_\_\_\_\_.

D S the disability is an industrial disability.

D S The commencement date for permanent partial disability benefits, if any are awarded, is the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Rate of Compensation.

At the time of the alleged injury,

D S claimant's gross earnings were \$\_\_\_\_\_ per week.

D S claimant was ( ) married or ( ) single.

D S claimant was entitled to \_\_\_\_\_ exemptions.

The parties believe the weekly rate to be \$\_\_\_\_\_ based on the above.

(OVER)

Affirmative Defenses Encircle "A" for asserted or "W" for waived.

- A W Defense of \_\_\_\_\_ under IC section 85.16.
- A W Lack of timely notice under IC section 85.23.
- A W Untimely claim under IC section 85.26.
- A W Other, specify: \_\_\_\_\_.

Medical Benefits. If no longer in dispute check here ( ).

Identify type of dispute by entering checkmark below:

- ( ) Claimant seeks payment of medical expenses. Attach itemized list.
- ( ) Claimant seeks independent evaluation under IC section 85.39.
- ( ) Claimant seeks alternate care under IC section 85.27.

With reference to the attached itemized list of disputed medical expenses:

- D S The fees or prices charged by providers are fair and reasonable.
- D S The treatment was reasonable and necessary.
- D S Although disputed, the medical providers would testify as to the reasonableness of their fees and/or treatment set forth in the listed expenses and defendants are not offering contrary evidence.
- D S The listed expenses are causally connected to the work injury.
- D S Although causal connection of the expenses to a work injury cannot be stipulated, the listed expenses are at least causally connected to the medical condition(s) upon which the claim of injury is based.
- D S The requested expenses were authorized by defendant(s).

Credits Against Any Award. If no longer in dispute, check here ( ).

- D S Prior to hearing, claimant was paid \_\_\_\_\_ weeks of compensation at the rate of \$\_\_\_\_\_ per week.
- D S Defendant(s) are entitled to credit under IC section 85.38(2) for payment of sick pay/disability income in the amount of \$\_\_\_\_\_ or for payment of medical/hospitalization expenses in the amount of \$\_\_\_\_\_.

Other Issues/Stipulations.

- D S Specify:

Disputed Costs. If a party wishes specific taxation of costs in the decision, check here ( ) and attach an itemized list and proof of payment.

- D S The costs listed in the attachment have been paid.

Signed and agreed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Attorney for Claimant

\_\_\_\_\_  
Attorney for Defendant(s)

**ORDER**

The above report was submitted at the hearing. At that time, it was found to be a correct representation of disputed issues and stipulations and the report was approved and accepted into the record of this case.

\_\_\_\_\_  
Deputy Workers' Compensation Commissioner

14-0047 (7/99)

