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| **Before the Iowa Workers’ Compensation Commissioner** | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | , | |  |  | | --- | --- | | File No(s).: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | Claimant, |  |
|  | vs. |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | , |
|  | Employer, |  | **Hearing Report** |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | , |
|  | Insurance Carrier, |  |
|  | Second Injury Fund of Iowa | , |
|  | Defendant(s). |  |

Under Rule 876 IAC 4.19(3)(f), the parties in the above-captioned case jointly submit this Hearing Report, which defines the claims, defenses, and issues submitted to the presiding deputy commissioner.

# Employer-Employee Relationship.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The existence of an employer-employee relationship at the time of the alleged injury. |

# Injury.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant sustained an injury, which arose out of and in the court of employment, on the following date(s): \_\_\_\_. |

# Causation to Disability.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The alleged injury is a cause of temporary disability during a period of recovery. |
| \_\_\_\_ | 1. The alleged injury is a cause of permanent disability. |

# Entitlement to Temporary Disability and/or Healing Period Benefits.

No longer in dispute.

Claimant is seeking either temporary total disability, temporary partial disability, or healing period benefits for the following time period(s): \_\_\_\_.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. If defendant(s) are liable for the alleged injury, claimant is entitled to benefits for this period of time. |
| \_\_\_\_ | 1. Although entitlement cannot be stipulated, claimant was off work during this period of time. |

# Entitlement to Permanent Partial Disability Benefits.

No longer in dispute.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. 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,

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The disability is a scheduled member disability to the \_\_\_\_. |
| \_\_\_\_ | 1. The disability is an industrial disability. |
| \_\_\_\_ | 1. The commencement date for permanent partial disability benefits, if any are awarded, is \_\_\_\_. |

# Rate of Compensation.

At the time of the alleged injury,

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant’s gross earnings were $\_\_\_\_ per week. |
| \_\_\_\_ | 1. Claimant was:   Married.  Single. |
| \_\_\_\_ | 1. Claimant was entitled to \_\_\_\_ exceptions. |

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

# Affirmative Defenses.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Defense of \_\_\_\_ under Iowa Code section 85.16. |
| \_\_\_\_ | 1. Lack of timely notice under Iowa Code section 85.23. |
| \_\_\_\_ | 1. Untimely claim under Iowa Code section 85.26. |
| \_\_\_\_ | 1. Other: \_\_\_\_ |

# Medical Benefits.

No longer in dispute.

Claimant seeks:

Payment of medical expenses. Itemized list of medical expenses is attached.

Independent medical examination (IME) under Iowa Code section 85.39.

Alternate care under Iowa Code section 85.27.

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

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The fees or prices charged by providers are fair and reasonable. |
| \_\_\_\_ | 1. The treatment was reasonable and necessary. |
| \_\_\_\_ | 1. 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. |
| \_\_\_\_ | 1. The listed expenses are causally connected to the work injury. |
| \_\_\_\_ | 1. 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. |
| \_\_\_\_ | 1. The requested expenses were authorized by defendant(s). |

# Credits Against Any Award.

No longer in dispute.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Prior to hearing, claimant was paid \_\_\_\_ weeks of compensation at the rate of $\_\_\_\_ per week. |
| \_\_\_\_ | 1. Defendant(s) are entitled to credit under Iowa Code section 85.38(2) for payment of:   Sick pay/disability income in the amount of $\_\_\_\_.  Medical/hospitalization expenses in the amount of $\_\_\_\_ . |

# Second Injury Fund (SIF).

|  |  |
| --- | --- |
| \_\_\_\_ | 1. Claimant sustained a prior qualifying loss to the \_\_\_\_ on \_\_\_\_. |
| \_\_\_\_ | 1. The functional loss from the prior qualifying loss is of \_\_\_\_ % of the \_\_\_\_ . |
| \_\_\_\_ | 1. Claimant sustained a compensable loss to the \_\_\_\_ on \_\_\_\_. |
| \_\_\_\_ | 1. The functional loss from the second qualifying loss is \_\_\_\_ % to the \_\_\_\_ . |
| \_\_\_\_ | 1. Claimant believes the commencement date of SIF benefits, if any are awarded, is \_\_\_\_.   If disputed, SIF believes the commencement date for PPD benefits, if any are awarded, is \_\_\_\_. |
| \_\_\_\_ | 1. SIF is entitled to credit under Iowa Code section 85.64 for \_\_\_\_. |

# Additional Issues, Stipulations, and/or Explanation.

Click here to add additional issues, stipulations, and/or explanation

# Disputed Costs.

Claimant wishes specific taxation of costs in the decision. An itemized list of costs and proof of payment is attached.

|  |  |
| --- | --- |
| \_\_\_\_ | 1. The costs listed in the attachment have been paid. |

# Agreement and Signatures.

The parties agree that the hearing report fully and accurately defines the claims, defenses, and issues submitted to the presiding deputy commissioner.

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| --- | --- | --- | --- | --- |
|  | |  |  | |
| Signature of Attorney for Claimant | |  | Signature of Attorney for \_\_\_\_ | |
| Name: | \_\_\_\_ |  | Name: | \_\_\_\_ |
| Date: | \_\_\_\_ |  | Date: | \_\_\_\_ |
|  | |  |  |  |
| Signature of Attorney for \_\_\_\_ | |  |  |  |
| Name: | \_\_\_\_ |  |  |  |
| Date: | \_\_\_\_ |  |  |  |