

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

<p>_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).</p>	<p>File No(s).: _____ _____</p> <p style="text-align: center;">Answer Concerning Vocational Rehabilitation Program Benefit</p>
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1. Employer's name is: _____

2. Employer's address is: _____

3. Insurance carrier's name is: _____

4. Insurance carrier's address is: _____

5. Employer/insurance carrier admit the allegations in the following paragraph(s) of the Petition:

6. Employer/insurance carrier deny the allegations in the following paragraphs(s) of the Petition:

7. Employer/insurance carrier:

- Consent to pay the requested vocational rehabilitation program benefit.
- Do not consent to pay the requested vocational rehabilitation program benefit because:

8. Employer/insurance carrier:

- Waive an evidentiary hearing under Iowa Code section 17A.12.
- Request an evidentiary hearing.

Signature of Attorney for Defendant(s) Name (PIN): _____ Email: _____ Phone: _____ Fax: _____ Address: _____ _____ _____	-or-	Signature of Representative of Employer Name, Title: _____ Email: _____ Phone: _____ Fax: _____ Address: _____ _____ _____
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CERTIFICATE OF SERVICE

I, _____, hereby certify that a copy of this document was served upon counsel of record for each party or each unrepresented party to this case on _____, by:

- Iowa Workers' Compensation Electronic System (WCES)
- Other: _____

Signature	Date
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The information provided will be open for public inspection under Iowa Code sections 22.11 and 86.45(1).