THE DISTRICT OF COLUMBIA GOVERNMENT

DEPARTMENT OF EMPLOYMENT SERVICES

OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, D.C. 20019 (202) 671-1000

APPLICATION FOR FORMAL HEARING

CLAIMANT: _____

EMPLOYER: _____

INSURANCE COMPANY: _____

DATE OF INJURY: _____

THIS IS TO ADVISE YOU A HEARING IS REQUESTED PURSUANT TO SECTION 26, D.C. LAW 3-177.

PLEASE NOTIFY ME OF THE SCHEDULED DATE AT THE FOLLOWING ADDRESS.

_____

NAME OF REQUESTER

_____

NAME OF FIRM, COMPANY OR ORGANIZATION, IF ANY

_____

ADDRESS ZIP CODE

_____

DATE

IF REQUESTER IS REPRESENTING CLAIMANT OR ANOTHER PARTY, SO INDICATE HERE: _____

FORM NO.20 DCWC