THE DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(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.

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

____

____
ADDRESS ZIP CODE

____
DATE