STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205 - Binghamton, NY 13902-5205

COVER SHEET - APPLICATION FOR BOARD REVIEW

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury

Claimant's Name	Address

TO THE APPLICANT: This Application for Board Review may be filed with the Board by fax (1-877-533-0337; see Subject No. 046-144), e-mail (**wcbclaimsfiling@wcb.ny.gov**); see Subject Nos. 046-144 and 046-375), personal delivery to a Board District Office, or by mailing to one of the Board addresses listed at the top of this page. A copy of this Application must be served on all parties in interest. Sections 1 and 2 on the reverse side of this form must be completed. The failure to supply all information requested by this form may result in dismissal of the Application. If an additional attorney fee is being requested, Form OC-400.1 must be attached and served on all parties. For Applications filed by a carrier, TPA or self-insured employer, an up-to-date Form C-8/8.6 must be attached and served on all parties.

TO ALL OTHER PARTIES: Any Rebuttal to this Application must be served on the Board within 30 days following the date on which the Application was served on the parties, as specified in Section 2 on the reverse side of this form.

1. This application is made on behalf of:
   ☐ Claimant ☐ Employer/Carrier _____ (name) ☐ Special Funds ☐ Uninsured Employers' Fund
   ☐ Attorney/Licensed Representative

2. This application is made for: (choose only one)
   ☐ Review of WCLJ Decision (WCL § 23 and 12 NYCRR 300.13)
   ☐ Rehearing or Reopening (12 NYCRR 300.14)

3. The filing date of the decision which is the subject of this application is: _____

4. The remedy sought is:
   ☐ Administrative Correction of Decision ☐ Modification of the Decision
   ☐ Reversal of the Decision ☐ Rescission of the Decision

5. This application arises from an expedited hearing: ☐ Yes ☐ No

6. Specify the issue(s) for review:

☐ Employer/employee relationship	☐ Average Weekly Wage	☐ Special Funds Liability
☐ Accident	☐ Authorization of Treatment	☐ Attorney/Licensed Representative Fee
☐ Occupational Disease	☐ Period of Disability	☐ Facial Award
☐ Notice	☐ Degree of Disability	☐ Section 32 Denial
☐ Causal Relationship	☐ Reimbursement	☐ Disability Benefits
☐ Death Benefits	☐ Penalty	☐ Discrimination
☐ Timely Claim Filing	☐ WCL § 114-a Disqualification	☐ Policy Coverage
☐ Jurisdiction	☐ Apportionment	☐ ATF Deposit

7. Specify the grounds for review (foundation, basis, or points) relied upon in raising the issues identified above.

_____

_____

_____

_____

8. Make reference to the record below, or such part thereof, as is relevant to the issue(s) and ground(s) raised in this application. Also, indicate when and where such issue(s) and ground(s) were raised before the Workers' Compensation Law Judge.

Hearings (if minutes are not transcribed, so indicate):

_____

_____

_____

_____

Documents: provide name and document ID number:

_____

_____

_____

_____

Transcripts: provide date and document ID number:

_____

_____

Non-Scanable Evidence or Videotape (WMV or AVI format only)**:** provide description:

_____

_____

9. List the following period(s) and/or medical benefits awarded which will be withheld pending this application:

_____

_____

10. A Form OC-400.1 for an increased attorney's fee that has been properly served has been included with this application for consideration by the Board.
☐ Yes ☐ No

Certification: By signing this document in the space provided below, I certify that this application has a good faith basis in law and fact, has been instituted with reasonable grounds, and has been served upon all parties at the addresses listed in the affirmation or affidavit of service below. I understand that the Workers' Compensation Law provides for substantial penalties for instituting or continuing proceedings without reasonable grounds and/or for the purpose of delay. I understand that if this application is withdrawn for any reason or if any of the issues raised are resolved by the parties, I must immediately notify the Board and the parties served in writing.

Signature of Person Preparing Form _____ Date _____/_____/_____

Print Name_____ Title _____ Phone Number (_____)_____

Address _____

SECTION 1

AFFIRMATION

STATE OF NEW YORK, COUNTY OF _____ ss: I, the undersigned, am an attorney duly admitted to the practice of law in the courts of the state of New York. I hereby certify that I have complied with the filing and service requirements for this Application for Board Review in the manner described in Section 2 below.

I affirm that the foregoing statements are true under penalties of perjury.

Dated _____ Signature _____

Signer's Name (Print) _____

AFFIDAVIT

STATE OF NEW YORK, COUNTY OF _____ ss: I, _____, being duly sworn, say: I am over 18 years of age. I hereby certify that I have complied with the filing and service requirements for this Application for Board Review in the manner described in Section 2 below.

Sworn to before me on _____ Signature _____

_____ Signer's Name (Print) _____

Notary Public

SECTION 2

A. Method by which Application was Filed with the Board (Check One):

☐ Fax (1-877-533-0337) ☐ E-Mail (wcbclaimsfiling@wcb.ny.gov) ☐ Mail (specify date below) ☐ Personal Delivery (specify date below)

Date of Mailing: _____ Date of Personal Delivery:_____

B. Method of Service on the Parties (Check One): ☐ Mail ☐ Personal Delivery

Specify Date of Mailing or Personal Delivery _____

C. Names and addresses of all Parties Served: (Attach additional sheets if necessary.)