MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
P.O. Box 58
Jefferson City, MO 65102-0058

DIVISION OF WORKERS' COMPENSATION

INJURY NUMBER

MOTION FOR LEAVE TO WITHDRAW

		-									

+

_____, **Employee**

vs.

_____, **Employer**

and

_____, **Insurer**

_____, **Third Party Administrator**

Date of Accident/ Occupational Disease: _____

MOTION FOR LEAVE TO WITHDRAW

*On behalf of the ☐ Employee ☐ Employer / Insurer / Third Party Administrator *(Please circle the appropriate party.)*
COMES NOW, the undersigned attorney and requests Leave to Withdraw as attorney for the _____ *(specify the name of the party)*. In support of the Motion, the undersigned states as follows: _____

Are you requesting a hearing to be set on this Motion: ☐ Yes ☐ No Is this case set on the docket: ☐ Yes ☐ No
Is it set for a _____ Pre-hearing _____ Mediation _____ Hearing.
The docket date is _____. Respectfully submitted,

Signature _____
Are you filing a Lien in this case: ☐ Yes ☐ No Attorney Name _____
Law Firm _____
Address _____
Phone No. _____
Fax No. _____
Bar No. _____
Email Address _____

Leave Granted: _____
Administrative Law Judge

Date: _____

CERTIFICATE OF SERVICE

I certify that a copy of this Motion for Leave to Withdraw was mailed or hand delivered to all parties of record, or if represented by an attorney, to their attorneys of record this _____ day of _____, 20____.

Attorney's Signature _____ Bar No. _____
Attorney's Name *(Printed)* _____ Date _____
Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP

*The attorney submitting this withdrawal has notified or attempted to notify his/her client of the intent to withdraw pursuant to Missouri Supreme Court Rule, Rule 4-1.16.