MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058
labor.mo.gov/DWC

1. INJURY NUMBER

+ ☐☐ - ☐☐☐☐☐☐☐

REQUEST FOR HEARING – HARDSHIP OR §287.203 HARDSHIP HEARING

Please check which hearing is requested: ☐ **§287.203** ☐ **Other**
Note: This form must be completed in its entirety and must be typed or hand printed in black ink.

Please submit this form to the appropriate adjudication office.

		2. Date of Injury
3. Employee	4. Attorney for Employee Email Address:	5. Case Venue 6. Party Requesting the Hearing
7. Employer(s)/Insurer(s)	8. Attorney for Employer/Insurer Email Address:	9. Second Injury Fund Involved ☐ Yes ☐ No 10. Attorney for Second Injury Fund

11. Please state all issues to be resolved by hearing.

_____

_____

11a. The party requesting the hearing has conferred with all attorneys of record, whose names are listed here, regarding disputed issues and listed them above.

12. Has all necessary discovery been completed? ☐ Yes ☐ No 12a. Are parties prepared to present their evidence at hearing? ☐ Yes ☐ No

(The administrative law judge will consider a hearing request upon completion of discovery and parties' preparedness to present evidence at hearing.)

13. The party requesting the hearing has conferred with the other attorney of record and estimates the hearing will last approximately _____hour(s).

14. The party requesting a hearing must provide all exclusionary dates after conferring with all attorneys of record for all offices except Kansas City. The Exclusionary dates are

15. For cases venued in Jefferson City and Joplin, the party requesting the hearing has contacted the applicable office's docket clerk for available dates and has made a good faith effort to discuss these available dates with the other attorneys of record. Based on this information, the following dates, in order of preference, are requested for a hearing:

CERTIFICATE OF SERVICE

I, the undersigned, certify that, to the best of my knowledge, information and belief, the information set forth in this Request for Hearing is true and accurate, and I further certify that a copy of this Request for Hearing has been mailed or hand-delivered to all attorneys and/or parties of record this _____ day of _____, 20___.

Attorney's Signature _____

Bar Number _____ Date _____

Attorney's Name *(Printed)* _____

Address _____

_____

Phone Number _____

DIVISION USE ONLY

COMPLETED BY DIVISION OF WORKERS' COMPENSATION

Approved _____ Denied _____

By _____ Date _____

Please visit our website at **labor.mo.gov/DWC** if you have any questions about your rights or benefits under the Workers' Compensation Law. Keep a copy for your records.

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711