



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

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**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.

3. Employee	4. Attorney for Employee Email Address: _____	2. Date of Injury
7. Employer(s)/Insurer(s)	8. Attorney for Employer/Insurer Email Address: _____	5. Case Venue
		6. Party Requesting the Hearing
		9. Second Injury Fund Involved <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

<p>DIVISION USE ONLY</p>

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

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