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Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032
1-800-342-5354
FaX: 651-284-5731

Request for Formal Hearing

(under M.S. 176.106 or 176.305)

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

RF03

DO NOT USE THIS SPACE

WID or SSN	DATE(S) OF CLAIMED INJURY
EMPLOYEE VS.	
EMPLOYER AND	
INSURER AND	
ADDITIONAL PARTIES (INCLUDING INTERVENORS)	

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE ABOVE NAMED PARTIES AND THEIR ATTORNEYS:

The above-named party, _____, requests a formal hearing. An administrative decision on the issues was previously issued by:

(Name) _____.

The decision was served and filed on: _____ (date). The specific issues in dispute and the specific reason(s) for disputing the decision are as follows:

Copies of this request have been served on all parties and their attorneys who are listed with addresses and attorney registration numbers as follows: (attach additional sheet if necessary)

Employee:	Employee Attorney:
Employer:	Employer/Insurer Attorney:
Insurer:	Other Party (Specify): Name and address of other parties

REQUESTOR SIGNATURE	ATTORNEY FOR PARTY SIGNATURE		
REQUESTOR PRINTED NAME	ADDRESS		
DATE	CITY	STATE	ZIP CODE
	ATTORNEY REGISTRATION #	PHONE # (include area code)	

INSTRUCTIONS

This form must be served on each party and each party's attorney, and received by the Department within 30 days after the date the decision was served and filed. Issues and reasons for the request must be specifically listed. For example, a general statement that the prior decision is not in conformity with the Workers' Compensation Act is not a specific statement of the disputed issues.

All requests will be referred to the Office of Administrative Hearings for a formal hearing before a workers' compensation judge.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.