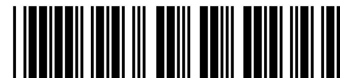
Office of Administrative Hearings
P.O. Box 64620
St. Paul, MN 55164-0620

OR*

Department of Labor and Industry
P.O. Box 64221
St. Paul, MN 55164-0221
Fax: (651) 284-5731

State of Minnesota
Office of Administrative Hearings

*Note: Motions to Intervene must be filed with the Office of Administrative Hearings unless applicant intends to intervene in an administrative conference that is pending at the Department of Labor and Industry.



DO NOT USE THIS SPACE

WID number
Date(s) of claimed injury

Motion to Intervene

Print in ink or type.
Enter dates in MM/DD/YYYY format.

Employee vs.
Employer(s) and
Insurer(s) and

1. The applicant is filing this Motion to Intervene in the following disputes(s):

   Claim Petition dated ________________________ Rehabilitation Request* dated ________________________

   Medical Request* dated _____________________ Request for Formal Hearing dated _____________________

2. The applicant, _________________________________ (name of entity filing this Motion to Intervene), has provided services or paid benefits to or on behalf of the employee and has a statutory right to intervene under Minnesota Statutes § 176.361.
3. Attached to this Motion to Intervene is an exhibit(s) itemizing the charges for services provided or payments made to or on behalf of the employee by the applicant from __________________ (date) to __________________ (date). The claim to-date is $________________. Upon request of a party or to present evidence of the intervention claim at hearing, the applicant acknowledges it will provide additional documentation, records and reports as required by law.
4. A determination in this case may affect the ability of the applicant to obtain payment from any source for the services provided or payments made to or on behalf of the employee as itemized in the attached exhibit(s).
5. The applicant's representative, who has authority to settle on behalf of the applicant, ________________________ (print name and title), can be contacted at ________________________ (phone number) and ______________________________ (email address).
6. Therefore, the applicant requests it be allowed to intervene as a party in the above-captioned proceeding and that payment for services provided or benefits paid be made, plus appropriate statutory interest.

Date signed	Signature of person filing motion			
	Printed name and title			
	Mailing address		Email address	
	City	State	ZIP code	Telephone

WID number
Date(s) of claimed injury

Proof of service

State of ________________________ }
}
County of ________________________ } ss.

I, ______________________________ state that on ________________________ I served a true and correct copy of the attached **Motion to Intervene,** by placing it in a properly stamped and addressed envelope, in the United States mail at _______________________, ________________, addressed as follows.

Employee	Employee attorney
Employer	Employer/Insurer attorney
Insurer	Other party (specify)
Other party (specify)	Other party (specify)

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Dated ____

Signature ____

Name ____

Address ____

City/State/ZIP ____

Telephone____