State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD

CASE No. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

VS

RESPONDENT

NAME

ADDRESS (including County)

ATTORNEY FOR PETITIONER

☐ NEW JERSEY REGISTRATION NUMBER ☐ SSN ☐ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

INSURANCE CARRIER

NAME (indicate if Not Covered or self-insured)

ADDRESS

CARRIER'S CLAIM FILE NUMBER

TO THE DIVISION OF WORKERS' COMPENSATION: (Applicant) _____ hereby makes application to the Division of Workers' Compensation to review the Order entered on _____ , _____ by _____ and respectfully states: The following is an accurate, succinct description of the factual, medical, and legal reasons for the relief sought in the Application: (Use additional sheets if necessary)

As To Claim Petitioner	D.O.B	Sex	Date of Injury	Date of Last Compensation Paid	Present Employment Status

This is the _____ application for Review or Modification of this award.
(Number)

What other facts are there that you believe important?

In occupational disease claims, list claims against other employers filed or to be filed for the same or similar occupational diseases.

NAME & ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT

Your Applicant therefore requests that the Division of Workers' Compensation determine the amount of compensation due the Petitioner from said Respondent, under Revised Statutes of New Jersey, Title 34, Chapter 15, and the Acts supplemental thereto and amendatory thereof, and that the Petitioner may be awarded costs in this proceeding, and such other or further relief as may be proper.

_____

(Applicant)

STATE OF NEW JERSEY
COUNTY OF

Subscribed and sworn or affirmed
to before me this day of
, 20

_____

This Application for Review or Modification of Formal Award has been presented by the Applicant to the Division of Workers' Compensation for hearing and determination. Unless an Answer is filed within 30 days of the date of service of the Application upon you, with the assignment clerk at the office to which the claim is assigned as indicated on the reverse side, and a copy served upon the Applicant's attorney, THE APPLICANT WILL PROCEED WITH PROOF OF CLAIM ACCORDING TO LAW AND MAY OBTAIN JUDGMENT AGAINST YOU.

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C.§ 405, and *N.J.S.A.* 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

DIVISION OF WORKERS' COMPENSATION