DISTRICT OF COLUMBIA
OFFICE OF ADMINISTRATIVE HEARINGS

PUBLIC SECTOR WORKERS' COMPENSATION PROGRAM HEARING REQUEST FORM

Use this form to request a hearing before an Administrative Law Judge to appeal a decision issued pursuant to D.C. Code §§ 1-623.24(b) or 1-623.24(d) by the District of Columbia Public Sector Workers' Compensation Program (PSWCP) or request for a hearing pursuant to D.C. Code § 1-623.06a.

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE
For Help and Information, call (202) 442-9094

APPEAL DEADLINE: Your request must be received by the Office of Administrative Hearings (OAH) within **thirty (30)** calendar days from the date that the PSWCP issued the decision. If the 30-calendar-day filing deadline falls on a Saturday, Sunday, or a legal holiday, the deadline is extended to the next business day OAH is open.

PERMANENT DISABILITY DETERMINATION DEADLINE: Requests for hearing on permanent disability must be filed within the last 52 weeks of a Claimant's receipt of 500-weeks of TTD benefits.

If you file a request after the deadline, the judge may dismiss your case. You are responsible for making sure your request is filed before the appeal deadline. No one is authorized to give you different instructions about the deadline.

Please submit with this form any necessary attachments. If you are appealing a decision, you must also include a copy of the PSWCP Decision. You may submit this form first, but we cannot schedule a hearing or proceed with your appeal until you submit a copy of the PSWCP Decision you are appealing. This request and any attachments shall not exceed 15 pages.

Claimant's Name: _____ **Representative (if any):** _____

Claimant's Full Address (with unit number, zip code): **Rep.'s Full Address (with unit number, zip code):**

Claimant's Telephone: _____ **Rep.'s Telephone:** _____
Claimant's E-mail: _____ **Rep.'s Fax:** _____
Claim Number: _____ **Rep.'s E-mail** _____
Employing Agency on Injury Date: _____

Type of Hearing Being Requested:

☐ A. Appeal of initial award denying compensation benefits pursuant to D.C. Code § 1-623.24(b);
☐ B. Appeal of modification of awarded benefits pursuant to D.C. Code § 1-623.24(d); or
☐ C. Request for permanent disability determination pursuant to D.C. Code § 1-623.06a.

If A or B, go to Sections I and IV. If C, go to Sections II, III and IV. (Use additional paper if necessary)

SECTION I. Reason for Disagreement with PSWCP Decision
(You **MUST** attach a copy of the Decision and answer all questions in this Section.):

A. Why do you consider the decision to be incorrect?

B. List detailed facts supporting the reason(s) for why the decision is incorrect?

C. What do you want the Judge to do?

➔ ➔ **TURN OVER FOR MORE INSTRUCTIONS** ➔ ➔

SECTION II. Permanent Impairment Hearing Request.
(You **MUST** attach a copy of the Notice of Benefits Expiration and answer all of the questions in this Section.)

A. Have you ever filed a claim for permanent disability in the past? ☐ **YES** ☐ **NO**

B. Has a qualified physician documented that you have reached maximum medical improvement for your disability and provided you with an impairment rating? ☐ **YES** ☐ **NO**

If *YES*, ***have physician complete Section III and attach supporting medical evidence.***

If *NO*, would you like the Program to schedule you for an evaluation? ☐ **YES** ☐ **NO**

SECTION III. ***To be completed by a Physician only*** trained and experienced in the use of the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides) A medical report containing all required information, including those requested below, may be submitted in lieu of completing this section. The medical report **must** identify the clinical diagnosis, diagnosis code, current clinical symptoms, current examination findings, MMI date, diagnostic test results, medical records reviewed, MMI date, and explain how you arrived at the impairment rating, citing to the specific page number, paragraph, and table relied upon within the AMA Guides applied.

A. Physician Information:

Name: _____ **Practice Name:** _____

Office Address: _____ **Office Phone No.:** _____

Office Fax No.: _____

B. Diagnosis or Nature of Disease or Injury

	Enter ICD 10 Code	ICD10 Description
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

C. Maximum Medical Improvement Date patient reached MMI: _____

D. Permanent Impairment Is there a permanent impairment? ☐ YES ☐ NO

Schedule loss of use of member or facial disfigurement. (Identify impairment rating according to the latest AMA Guidelines and attach separate sheet for additional body parts).

Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____

For each body part, you **must** submit medical evidence describing findings, relevant diagnostic test results, with citation to the specific page number, paragraph, and table relied upon within the AMA Guides. This may be submitted at a later date to be established by OAH, if not available at the time of filing.

☐ Check this box if supporting medical evidence, records, or report is not available at the time of filing.

E. Health Care Provider Certification: Signed under penalty of perjury.

Signature Date Specialty

SECTION IV. Claimant Certification. I have read this Hearing Request Form and I swear or affirm that the contents are true and accurate to the best of my knowledge.

CLAIMANT/REP'S SIGNATURE: _____ **DATE:** _____

Will you need an INTERPRETER for the hearing? If so, what LANGUAGE? _____

Will you need a reasonable accommodation? If so, please explain: _____

SECTION V. HOW TO FILE: You **MUST** file this form with the **Office of Administrative Hearings** **and** ***serve a copy*** of your request on **ORM**. Do not file this with the PSWCP, ORM, or the Department of Employment Services.

By Mail or In Person. You may file this form in person, weekdays between 9:00 a.m. and 5:00 p.m., or by mail to the following address. You will need photo identification to enter the building:

Office of Administrative Hearings
441 Fourth Street, NW, Suite 450 North
Washington, DC 20001-2714

If filed by mail, your request must be received by OAH by the appeal deadline.

By Fax. You may file this form by fax to **(202) 442-4789**. Faxes received after 5:00 p.m. or on any non-business day are considered "filed" on the next business day. Forms sent by fax will not be filed unless it is complete and legible when received.

By E-mail. You may file this form by emailing **OAH.FILING@DC.GOV**. E-mails received after 5:00 p.m. or on non-business days are considered filed the next business day. Attach a completed copy of this form to your email.

You may serve ORM by delivering, mailing, faxing or sending a copy of your filing by commercial carrier at:
D.C. ORM, 441 4th Street, NW, Suite 800 S, Washington, DC 20001-2714; Fax: (202) 535-1130

RULES: The Rules of Procedure for the OAH may be found at oah.dc.gov and the OAH Hearings Resource Center.