Utah Labor Commission

Adjudication Division

160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800
casefiling@utah.gov

Note: PLEASE TYPE OR PRINT IN BLACK INK

Employer (Petitioner)

Employer's Mailing Address

City, State and Zip Code

Employer's E-Mail Address

Petitioner's Workers' Comp Insurance Carrier

Insurance Carrier's Mailing Address

City, State and Zip Code

Insurance Carrier's E-Mail Address

vs.

Respondent (Employee)

Respondent's Mailing Address

City, State and Zip Code

Respondent's Phone Number

NOTICE OF FILING APPLICATION FOR HEARING FOR TERMINATION OR REDUCTION OF COMPENSATION

Petitioner hereby notifies respondent that an Application for Hearing for Termination or Reduction of Compensation has been filed with the Utah Labor Commission.

This application for hearing requests the Commission to:

☐ Terminate temporary total disability compensation

☐ Reduce weekly temporary total disability compensation by $ _____

A hearing will be scheduled by the Adjudication Division of the Commission within 30 days of filing

this Application.

Printed Name of Attorney for Petitioner State Bar #

Signature of Attorney for Petitioner

Attorney's Mailing Address

City State Zip Code

Telephone Number

FAX

E-Mail Address

I certify that on this _____ day of , 20 ____, a copy of the attached Notice of Request of Termination or Reduction of Compensation in the case of , Petitioner vs. , Respondent, was mailed first class, postage prepaid, to the respondent at the following address:

Respondent Name

Respondent Address

City State Zip Code

Print Name

Signature