ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION FOR REVIEW OF ARBITRATION DECISION

To appeal an arbitration decision, file two copies of this form within 30 days of receipt of the decision.

_____ Case # _____ WC _____
Employee/Petitioner

v.

_____
Employer/Respondent

The petitioner ____ respondent ____ requests the Commission to review the arbitration decision for this case, filed on _____ and received on _____ , and to take the following steps:

1. Furnish a transcript of the arbitration hearings, including all exhibits, to be presented to the Commission.
   I guarantee to pay for the cost to prepare the transcript within 30 days from the court reporter's written request, even if I later withdraw this appeal, and enter myself as surety therefor. *Note:* The first party to file a petition will be charged for the cost to prepare the transcript (original rate).
   Provide ____ copy/copies of the transcript. I similarly guarantee payment at the copy rate.

2. Extend the time allowed to file the transcript or the agreed statement of facts by 30 days past the time allowed by statute or stipulation.

3. Consider the issues checked below to which I take exception:

ACCIDENT
____ Did it occur?
____ Did it arise out of employment?
____ Was it in the course of employment?
____ Is the date correct?

BENEFIT RATES
____ Are the benefit rates correct?
____ Are the wage calculations correct?

EMPLOYMENT
____ Was there an employer-employee relationship?

JURISDICTION
____ Does the Commission have jurisdiction?

MEDICAL EXPENSES
____ Is there a causal connection?
____ Is the charge reasonable?
____ Was the treatment reasonably necessary?
____ Is prospective medical care necessary?

NOTICE
____ Was the respondent given proper notice?

OCCUPATIONAL DISEASE
____ Was there an exposure?
____ Was there a disease?
____ Did it arise out of employment?
____ Was it in the course of employment?
____ What was the last date of exposure?

OTHER (explain) _____

PENALTIES AND FEES
____ Section 16
____ Section 19(k)
____ Section 19(l)

PERMANENT DISABILITY
____ Is there a causal connection?
____ What is the nature and extent of the disability?

STATUTE OF LIMITATIONS
____ Was the case filed within the statute of limitations?

TEMPORARY DISABILITY
____ Is there a causal connection?
____ Is the duration of the disability correct?

4. Oral argument: Requested ____ Waived ____

_____ _____
Signature Telephone number

_____
Street address

_____ _____
Name (please print; attorneys, please include IC attorney code #)

_____
City, State, Zip code

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, _____ , affirm that I delivered ____ mailed with proper postage ____

in the city of _____ a copy of this form

at _____ **AM** on _____ to each party at the address(es) listed below.

_____

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

_____

Notary Public