ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION FOR IMMEDIATE HEARING
UNDER SECTION 19(b-1) OF THE ACT

ATTENTION. Complete both sides of this form.
The petitioner must certify the respondent received this petition and attachments 15 days before it is filed with the Commission.

_____ Case # _____ WC _____
Employee/Petitioner

v.

_____
Employer/Respondent

I, the petitioner, request an immediate hearing in this matter. I am unable to return to work at this time because of the injuries or disability caused by my employment, and I am not receiving Temporary Total Disability benefits or medical benefits. I further provide the following information:

1. Date, time, and location of accident _____ (Date) _____ (Time) _____ (Location)

2. Description of accident _____

3. Nature of injury _____

4. Notice of the accident was given to _____
orally ☐ in writing ☐ on _____ .

5. The employer has refused to pay proper compensation ☐ medical benefits ☐.

6. When was the last payment of Temporary Total Disability benefits, if any? _____

7. I did ☐ did not ☐ receive medical treatment for the accident from a medical provider selected by the employer.

8. Name and address of medical provider(s), and dates of treatments: _____
_____
_____
_____

9. In an attempt to obtain compensation and/or medical benefits, _____
Petitioner or petitioner's attorney
conferred with _____ by telephone ☐ in person ☐
Respondent or respondent's representative
on _____ , but they were unable to resolve this dispute.
Date

10. Name and address of each witness to the accident, and any other person who will support the employee's allegations:

ATTENTION, PETITIONER. You must submit the following items with this petition:

11. A recent statement, signed by a medical provider, that you are unable to return to work because of the accident, and such other documents that show you are entitled to benefits:
    a) your history of the accident;
    b) a description of the injury and medical diagnosis;
    c) the medical services you have received and are now receiving;
    d) the physical activities you cannot currently perform because of this injury; and
    e) the prognosis for recovery.
12. A signed authorization for the employer to review all related medical records;
13. Complete copies of any documents in your possession that will support your allegations, provided the employer pays reasonable copying costs; and
14. A list of all documents you have demanded by subpoena that will support your allegations.

_____ _____

Signature of petitioner or petitioner's attorney Date

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

_____ _____

Street address

Telephone number

_____

City, State, Zip code

ATTENTION, RESPONDENT. Send this petition to your insurance carrier or claims office immediately. According to Commission Rules, you must file a *Response to the Petition for an Immediate Hearing* within 15 days from the date you received notice that this petition was filed with the Commission. If you fail to respond, you will not be able to introduce evidence in defense of this claim.

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 ☐ sent by certified mail (return receipt requested) ☐

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