

**STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL**

This form is for use by claimant's attorney or licensed representative ONLY. Unrepresented claimants should use Form RFA-1W or ask for Board assistance.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS						3. DATE OF INJURY		
1. WCB CASE NO.			2. CARRIER CASE NO. (If known)			mm	dd	yy
NAME						ADDRESS TO WHICH NOTICES SHOULD BE SENT		
4. CLAIMANT		Check if new address: <input type="checkbox"/>				APT. NO.		
5. EMPLOYER (at time of Injury)								
6. CARRIER								
7. ATTORNEY OR LICENSED REP.								

8. INSTRUCTIONS: The claimant seeks Board action regarding the claim identified above for the following reasons (check all that apply). Please note that the required documentation identified below must be attached to the form and submitted to the Board or must be referenced in the space provided below** (by date, name or title of document, and form ID) if it is already in the Board's electronic file. This form must be mailed, faxed or e-mailed to the Workers' Compensation Board. (See mailing and e-mail filing addresses on reverse side).

Compensation:

a. Payments have been suspended or reduced on _____.

b. Payments should be suspended as claimant returned to work at full wages on _____.

c. Payments should be adjusted as claimant is working at reduced earnings as of _____. (documentation of medical disability and current earnings required)

d. Payments should be adjusted as claimant has concurrent employment. (documentation of weekly gross pay preceding injury and statement from second employer regarding lost time required)

e. Payments should begin as claimant is not working as of _____. (medical documentation indicating disability required)

f. Payments should be resumed as claimant has been released from incarceration on _____ and now seeks benefits. (medical documentation indicating disability and release from custody documentation required)

g. Payments have not been paid as directed by Decision filed on _____.

h. Payments have not included payment of the attorney/licensed representative's fee of \$ _____ directed by Decision filed on _____.

Medical Issues:

i. Claimant's medical condition has changed. (medical documentation indicating change required)

j. Claimant's request for medical treatment has been denied or has not been addressed. (documentation indicating denial of request for medical treatment required. Please use Form MG-2 for variance denials.)

k. Claimant's disability is now permanent. (medical Form C-4.3, Doctor's Report of MMI/Permanent Impairment required)

Check this box if the claimant was under 25 years of age at time of accident.

Check this box if the claimant accepts the carrier's opinion on the severity of disability/loss of use.

l. Claimant's request for medical and transportation reimbursement has been denied or not addressed. (receipts and Form C-257 required)

Other:

m. Parties have entered into a stipulation. (Form C-300.5 or written stipulation required)

n. Parties have reached an agreement and seek a Proposed Conciliation Decision. (Form C-312.5 or proposed findings required)

o. Claimant has discontinued or settled a lawsuit pertaining to the accident/injury of this claim. (documents indicating discontinuance, settlement, or closing statement required)

p. Claimant has new or requested documentation regarding _____ (documents required)

q. Other (explain fully in the space provided below.)

**Document reference information (date, name/title, form ID): _____

I certify that this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies). I also certify that (check one box below):

I have discussed the issue(s) above with the opposing party(ies) or its representative(s) (give name of person contacted) _____ on (date) _____ and that: (check one)

no settlement of the issue(s) could be reached. settlement of the issue(s) was reached (documentation required).

I have attempted to contact (name) _____ on (date) _____ to discuss the issue(s) above, that I have waited a reasonable time for a response, but that no discussion was forthcoming.

CERTIFIED BY (Please Print Name)	ATTY/REP ID NO.	DATE PREPARED	AREA CODE	TELEPHONE NUMBER
	R	mm dd yy		

An attorney/licensed representative fee is requested and Form OC-400.1 has been submitted.