

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION  WC(DO)-100 Generic i (r.7/10/2013)	CASE NO'S.:  VICINAGE:
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<b>PETITIONER</b>	NAME:		<b>ATTORNEY FOR PETITIONER</b>	FEDERAL EMPLOYER NUMBER		
	DATE OF BIRTH:	MEDICARE ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME:	ADDRESS:	
	ADDRESS:			TELEPHONE NUMBER (AREA CODE):		APPEARING:
<b>VS</b>						
<b>RESPONDENT</b>	NAME:		<b>INSURANCE CARRIER</b>	NAME <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> TPA		
	ADDRESS:			ADDRESS:		
<b>ATTORNEY FOR RESPONDENT</b>	NAME:		CLAIM NUMBER:			
	ADDRESS:		DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE:			
	TELEPHONE NUMBER (AREA CODE):		DESCRIBE (Briefly):			
	APPEARING:					

**This matter having come before the COURT on this \_\_\_\_\_ day of \_\_\_\_\_ , \_\_\_\_\_**  
**IT IS ORDERED**

ALLOWANCES	REIMBURSE	TAX IDENTIFICATION NUMBER	TOTAL AMT. ALLOWED	PAYABLE BY PETITIONER	PAYABLE BY RESPONDENT
MEDICAL FEE ALLOWED: <i>(report and/or testimony)</i>					
ATTORNEY(S) FEE:					
STENOGRAPHIC SERVICE:					

WE HEREBY CONSENT TO THE ENTRY AND FORM OF THIS ORDER AND ACKNOWLEDGE RECEIPT OF COPY:

\_\_\_\_\_  
PETITIONER'S ATTORNEY

\_\_\_\_\_  
PETITIONER (where applicable)

\_\_\_\_\_  
RESPONDENT'S ATTORNEY

\_\_\_\_\_  
JUDGE OF COMPENSATION

\_\_\_\_\_  
JUDGE'S NAME

\_\_\_\_\_  
DATE

THE ORIGINAL OF THIS DOCUMENT, SIGNED BY THE JUDGE OF COMPENSATION, WILL BE MAINTAINED ON FILE IN THE DIVISION OF WORKERS' COMPENSATION, PURSUANT TO N.J.S.A. 34:15-121 et. seq.