Form 101IR

October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
500 MERO STREET, 3RD FLOOR, FRANKFORT, KY 40601
Claim No. _____

Filed:

Application for Resolution – Interlocutory Relief

_____
Plaintiff

_____
Social Security Number/Green Card

_____
Birth Date Gender

_____
Mailing Address

_____
City/State/Postal Code

☐ Outside United States

_____
Country

_____

Defendant/Employer

_____

Mailing Address

_____

City/State/Postal Code

_____

Insurance Carrier

_____

Mailing Address

_____

City/State/Postal Code

_____

Additional Defendant Name

Mailing Address

City/State/Postal Code

_____

Reason for Joinder

Additional Other Defendant

Mailing Address

City/State/Postal Code

Reason for Joinder

I. Nature of Injury

1. Date and location of accident/injury:

_____ _____

Date of Injury Location of Injury (City/State/Postal Code)

☐ Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date and at the above location.

2. Describe how the accident/injury occurred:

_____

Cause of Injury: _____

3. Body part injured:_____

4. When and by what means did the plaintiff give notice of injury to the employer?

_____

5. Describe medical treatment, if any:

_____

The plaintiff/employee seeks interlocutory relief for the following **(check all that apply)**:

☐ Payment of medical expenses while the claim is pending.
Required attachment: Affidavit establishing that the requesting party is eligible for benefits under KRS Chapter 342, and that irreparable injury, loss or damage will result if interlocutory relief of medical expenses is not granted.

☐ Payment of temporary total disability income benefits while the claim is pending.
Required attachment: Affidavit establishing that the requesting party is eligible for income benefits under KRS Chapter 342, and that irreparable injury, loss or damage will result if interlocutory relief of temporary total income benefits is not granted.

☐ Vocational rehabilitation evaluation and services.
Required attachment: Affidavit showing immediate provision of rehabilitation services will substantially increase the probability that the plaintiff/employee will return to work.

In support of this application, the following additional documents are attached **(check all that apply):**

☐ Medical report or reports of Doctor(s) supporting entitlement of benefits.

_____
DOCTOR'S NAME

☐ An affidavit of plaintiff/employee establishing the grounds for which a finding of fact would reasonably believe all essential elements of a workers' compensation claim have been established.

☐ A statement of the grounds for which the plaintiff/employee believes he/she has a likelihood of success in the ultimate claim and an understanding that in the event awarded benefits exceed what plaintiff/employee is found ultimately entitled, credit will be given against both past due and future benefits.

Based upon the foregoing, _____ moves for the appropriate relief.

Plaintiff/Employee

Respectfully submitted,

_____

Plaintiff/Employee's Signature or Attorney for the Plaintiff

_____

Plaintiff/Employee's or Attorney's Street Address

_____

Plaintiff/Employee's or Attorney's City/State/Postal Code

Certificate Of Service

I certify that the original was mailed or filed electronically through the Department of Workers' Claims Litigation Management System to the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were served to the names and addresses of the parties given below:

_____

Plaintiff

_____

Plaintiff Address

_____

Carrier

_____

Carrier Address

Defendants

Name	Address

Other Recipients

Name	Address

Attestations:

☐ I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

_____

Plaintiff Signature