OPINION/ORDER

Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909
Fax: (517) 284-8920

Print Reset

Plaintiff's Social Security Number: _____ Plaintiff's Name(s): _____

Defendants(s)/Carrier(s)

A. _____

B. _____

C. _____

D. _____

Type of Claim (For statistical purposes only – not a part of this order)

A. ☐ General Disability B. ☐ Partial Wage Loss C. ☐ Specific Loss D. ☐ Permanent Total E. ☐ Death F. ☐ Misc.

Type of Award (For statistical purposes only – not a part of this order)

1. ☐ Granted Open 4. ☐ Medical Only 7. ☐ Stipulated Open 10. ☐ Dismissed 13. ☐ Granted Pet. to Stop 16. ☐ Voc. Rehab Review
2. ☐ Granted Closed 5. ☐ Voluntary Pay 8. ☐ Stipulated Closed 11. ☐ Granted Penalty 14. ☐ Denied Pet. to Stop 17. ☐ Atty. Fee Resolved
3. ☐ Denied 6. ☐ Voluntary Pay - 115 9. ☐ Withdrawn 12. ☐ Denied Penalty 15. ☐ Health Care Resolved 18. ☐ Other

Injury Date(s) Established	Average Weekly Wage	Discontinued Fringes	Date Discontinued
	$	$	
	$	$	

IRS Filing Status: A. ☐ Single B. ☐ Single/Head of Household C. ☐ Married/Joint D. ☐ Married/Separate

Dependents - Date of Marriage/Birth

Name	Date	Name	Date	Name	Date

IT IS FOUND that the employee is disabled and compensation shall be paid as follows:

Defendant/Carrier	At the weekly rate of	From	Through
	$		
	$		
	$		

IT IS FURTHER FOUND that the employee is still disabled and therefore it is ordered that defendant/carrier _____ shall pay compensation at the rate of $_____ per week, until further order. Interest shall be paid in accordance with Section 801(6).

IT IS FURTHER ORDERED that defendant/carrier _____ shall be responsible for medical expense(s) pursuant to Section 315 as follows:

IT IS FURTHER ORDERED that the maximum authorized attorney fee shall not exceed _____ percent of the compensation accrued (subject to the provisions of Section 858 (418.858) and Rule 14 (R408.44).

IT IS FURTHER ORDERED that:

_____
Magistrate

Signed on _____ at _____ Michigan

Unless a Claim for Review is filed by either party within 30 days from the date stamped on this Opinion/Order as "Mailed Date," this order shall become final. A request for review under MCL 418.858(1) must be filed within 15 days. The Claim for Review should be filed with the Workers' Disability Compensation Agency, PO Box 30016, Lansing, MI 48909 or by fax at (517) 284-8920.

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act 418.847(2), R418.54(1)
Completion: Mandatory
Penalty: None