



Claimant's Name: _____ Employer's Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Home Phone: () - Work Phone: () - Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: () - _____

Date of injury: (m/d/yyyy) Date of Notice to Employer of Injury: (m/d/yyyy)

I. Payment of Temporary Compensation Check one: Initial period Additional period Corrected compensation rate
(choose A, B, or C)

- A. Temporary Total at the compensation rate of \$ _____ per week. For this period of disability, disability began on _____ and the date of first payment was (m/d/yyyy).
- B. Temporary Partial at the compensation rate of \$ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on _____ (m/d/yyyy), and the date of first payment was _____ (m/d/yyyy).

Calculation of Temporary Partial Rate:

Average weekly wage before injury	\$ _____
- Current weekly wage	\$ _____
= Difference in wages before injury and now	\$ _____
x .6667	\$ _____
Temporary Partial Compensation Rate	\$ _____

- C. Salary in lieu of Temporary Total Partial (choose one) compensation in the amount of \$ _____ per week. For this period of disability, disability began on _____ (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was _____ (m/d/yyyy).

THIS SECTION SHALL BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY. EMPLOYER'S REPRESENTATIVE MUST DOCUMENT THE REASON FOR TERMINATION BELOW.

II. Termination of Temporary Compensation Temporary compensation payments were stopped _____ (m/d/yyyy) for the following reason:
on _____

- Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- Claimant agrees he/she is able to return to work and has signed a **Form 17**.
- Based on a good faith investigation, the claim is denied. Reason for denial: _____
- Claimant has been released to return to work without restrictions and employment has been offered.
- Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator Date (m/d/yyyy)

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:
If the employer's representative has terminated or suspended temporary compensation during the first 150 days after the employer received notice of the injury pursuant to Section 42-9-260, the claimant may request a hearing to dispute the termination or suspension of temporary compensation by signing below and filing the form pursuant to Reg. 67-207.

BY SIGNING BELOW I SWEAR OR AFFIRM THAT:
1) I HAVE RECEIVED THE FORM 15, SEC. II ABOVE TERMINATING OR SUSPENDING MY COMPENSATION; AND
2) I AM REQUESTING A HEARING TO DISPUTE THE TERMINATION OR SUSPENSION OF TEMPORARY COMPENSATION PURSUANT TO REG. 67-504(C).

Signature of Claimant or Legal Representative Date (m/d/yyyy)

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 the **Form 15** on claimant immediately on termination of compensation with documentation of the reason for the termination. Injured worker may contest termination of compensation within 150 days from the date of notice of the injury by completing section III of the **Form 15** and filing it with Judicial Department.