



**West Virginia
Workers' Compensation Fund**

CLAIM REOPENING APPLICATION

Step 1 - INJURED WORKER - Complete Section I and take this form to your doctor.

Step 2 - PHYSICIAN - Complete Section III and return this form to the injured worker for delivery to employer at time of injury, or send to the Workers' Compensation Fund at P.O. Box 3151, Charleston, WV 25332.

Step 3 - (Optional) - INJURED WORKER - Take this form to the employer for whom you worked at the time of your injury.

Step 4 - INJURED WORKER - Send completed form to Workers' Compensation Fund, P. O. Box 3151, Charleston, WV 25332. It is **your** responsibility to see that the Workers' Compensation Fund receives the completed form.

WC-125 Rev. 6-90

SECTION I - To be completed by the injured worker (Please print or type.)

1. Claimant's Full Name <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/> First Middle Last	2. Social Security Number <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/>	3. Date of Injury <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/>
4. Mailing Address <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/> Street or PO Box City State Zip Code	5. Telephone Number <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/>	6. Claim Number <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/>
<p>7. PLEASE CHECK APPROPRIATE BOX(ES). The claimant hereby petitions the Workers' Compensation Fund to reopen the above-captioned claim for the following reason(s):</p> <p><input type="checkbox"/> A. To be examined for Permanent Partial Disability due to:</p> <p style="margin-left: 40px;"><input type="checkbox"/> (1) Aggravation and/or progression of condition or disability resulting from compensable injury. <input type="checkbox"/> (2) Fact or facts pertaining to the disability or condition not previously considered by the Commissioner in prior findings.</p> <hr/> <p><input type="checkbox"/> B. To secure additional Temporary Total Disability benefits due to:</p> <p style="margin-left: 40px;"><input type="checkbox"/> (1) Aggravation and/or progression of condition or disability resulting from the compensable injury. <input type="checkbox"/> (2) Fact or facts pertaining to the disability or condition not previously considered by the Commissioner in prior findings.</p> <p style="margin-left: 40px;">Temporary Total Disability benefits are requested for the periods listed below:</p> <p style="margin-left: 40px;">From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____</p>		
<p>8. Have you suffered any other illnesses and/or injuries since the injury upon which this claim is based? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the nature of the illnesses and/or injuries, the dates of the illnesses and/or injuries, and the names and addresses of the physicians who treated you.</p> <hr/> <hr/> <hr/> <hr/>		
<p>9. Have you filed any other claims with the Workers' Compensation Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all claim numbers and/or dates of injuries.</p> <hr/> <hr/>		
<p>10. Have you drawn unemployment benefits since the injury covered by this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what period? From _____ To _____</p>		
<p>11. Do you continue to work for the employer for whom you were working at the time of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please give name and address of current employer.</p> <hr/> <hr/>		
Claimant's Signature _____		Date _____

SECTION II - (Optional) - To be completed by the employer for whom the claimant was working at the time of the injury covered by this claim (Please print or type.)

Although this section is optional, its completion may expedite the consideration of the petition.

1. Employer's Name, Address and Telephone No. <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/> Telephone Number _____	2. Do you disagree with any of the information contained in Section I or III? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined If yes, explain the information with which you disagree. Be specific. 	
3. The claimant began missing work again on _____ <hr style="border: none; border-top: 1px solid black; margin: 2px 0;"/>	4. The employer waives the ten (10)-day notice period and does not object to the Commissioner's immediately ruling on the claimant's petition. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature _____	Title _____	Date _____

SECTION III - To be completed by the physician in detail and a narrative report attached if necessary (Please print or type.)

1. Physician's Name and Address 	2. Physician's FEIN
3. Physician's Telephone Number 	
4. Were you the patient's treating physician in this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Date of examination upon which these findings are based: _____ / _____ / _____
6. Present Diagnosis: (give specific ICD9-CM code(s) and description(s).) _____ _____ _____ _____ _____	
7. Patient's Complaints: _____ _____ _____ _____	
8. Describe treatment rendered and part of body treated: _____ _____ _____ _____	
9. Describe in detail the patient's current physical condition including any restrictions on the patient's functional abilities. (A narrative report may be attached if indicated.) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
10. Is further treatment necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete form WC-215, Request For Authorization.	
11. Will the patient be able to continue working while undergoing treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. If this patient is unable to work at his regular job due to this injury, can he return to light duty? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate any work restrictions.	
13. Has there been an aggravation or progression of the patient's disability since being released to resume employment or being certified as having reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the physical findings relating to the aggravation or progression.	
14. Do the current physical findings relate to a disability or condition not previously considered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. If patient checked B(1) or B(2) in question 7 of Section I, please show periods of Temporary Total Disability. From _____ To _____ From _____ To _____	
16. If patient checked A(1) or A(2) in question 7 of Section I, please give your opinion of the degree of Permanent Partial Disability in terms of percentage of whole man. _____ %	17. In your opinion, is the current condition or disability a direct result of the injury or disease covered by this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. If the present diagnosis is for a disability or condition not previously considered in this claim, please attach a narrative report relating the current condition to the injury covered by this claim.	
<div style="display: flex; justify-content: space-between;"> _____ Physician's Signature _____ Date </div>	