

**State of Utah - Labor Commission
Adjudication Division**

160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800

casefiling@utah.gov

Note: PLEASE TYPE OR PRINT IN BLACK INK

Employer (Petitioner)	<p style="text-align: center;">APPLICATION FOR HEARING FOR TERMINATION OR REDUCTION OF COMPENSATION</p> <p>(NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned)</p> <p>Supporting Documentation Required for this Application:</p> <p>Proof of Service Notice of Request for Termination or Reduction of Compensation Persons with Knowledge List</p>
Employer's Mailing Address	
City, State and Zip Code	
Employer's E-Mail Address	
Petitioner's Workers' Comp Insurance Carrier	
Insurance Carrier's Mailing Address	
City, State and Zip Code	
Insurance Carrier's E-Mail Address	
vs.	
Respondent (Employee)	
Respondent's Mailing Address	
City, State and Zip Code	
Respondent's Phone Number	

PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. Date of industrial injury: Month _____ Date _____ Year _____ .
2. Petitioner requests respondent's compensation be (check one) _____terminated or _____reduced by \$_____ per week.
3. The basis for this reduction/termination is: _____ (list specific citation to § 34A-2-410.5 relied upon for this request). The petitioner alleges the following in support of this claim:

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.

Printed Name of Attorney for Petitioner/Respondent

Signature of Petitioner

Date

State Bar #

Petitioner's Telephone Number

Signature of Attorney for Petitioner/Respondent

Mailing Address for Attorney for Petitioner/Respondent

City/State/Zip Code

Telephone Number

FAX

E-Mail Address