Reset Form

REQUEST FOR ASSISTANCE

State Form 45442 (R2 / 5-06)

INDIANA WORKER'S COMPENSATION BOARD
OMBUDSMAN DIVISION
402 West Washington Street, Room W196
Indianapolis, Indiana 46204
Telephone: (317) 232-3808
Toll free: (800) 824-COMP

INSTRUCTIONS: *1. Please print or type*
2. Return completed request to the address listed at right.

EMPLOYEE INFORMATION	EMPLOYER INFORMATION
Name of employee	Name of employer
Address (*number and street*)	Address (*number and street*)
City, state, and ZIP code	City, state, and ZIP code
Telephone number ( )	Telephone number ( )
Social Security number *	County of employment
Date of birth (*month, day, year*)	**WORKER'S COMPENSATION INSURANCE COMPANY INFORMATION**
Date of accident (*month, day, year*)	Name of company
Nature of injury:	Address (*number and street*)
Have you hired an attorney? **	City, state, and ZIP code
If Yes, name and telephone number of attorney	Telephone number ( )
	Contact person(s)

Briefly describe your complaint / dispute (*attach additional sheets if necessary*):

I hereby request the Ombudsman Division of the Worker's Compensation Board to investigate my complaint. I understand that the Ombudsman Division is not a replacement for legal counsel, and that any specific legal questions should be addressed to my attorney.

Signature of employee	Date (*month, day, year*)

* PRIVACY NOTICE: This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

** You have no obligation to employ legal counsel under the Indiana Worker's Compensation and Occupational Diseases Acts.