APPLICATION FOR REVIEW BY FULL BOARD

State Form 1042 (R3 / 2-98)

Workers Compensation Board
402 W. Washington Street, Room W196
Indianapolis, IN 46204-2753

Application number

INSTRUCTIONS: ***This application must be filed within 30 days from the date of the award for which review is requested.***
The application should be filed in triplicate and captioned the same as the original claim for compensation. The application number assigned to the original cause should be shown on this application.

REVIEW BY THE FULL BOARD OF THE ORIGINAL AWARD		
Before the Worker's Compensation Board of Indiana: *(Name of plaintiff)*	**VS**	Name of defendant
Address of plaintiff (*number and street, city, state, ZIP code*)		Address of defendant (*number and street, city, state, ZIP code*)

The above named _____ respectfully makes application

for review by the Full Board of the award as to compensation made in the above captioned cause on the _____

day of _____, 19 _____, based upon, to wit:

1. that said award is not sustained by sufficient evidence; or
2. that said award is contrary to law.

☐ **I wish to order a transcript in this matter and ask that the court reporter contact me regarding said transcript. (*If you fail to indicate your desire for a transcript here, you must contact the court reporter immediately, as no continuance will be granted for this purpose after the hearing date is set.*)**

Signature of plaintiff or defendant	Signature of attorney
Address of attorney (*number and street, city, state, ZIP code*)	