Ohio | Industrial Commission

APPLICATION FOR LUMP SUM PAYMENT OF ATTORNEY FEE

SUBMIT THIS FORM TO:
Industrial Commission of Ohio
Lump Sum Payments
30 W. Spring St.
Columbus, Ohio 43215 **Fax: (614) 466-7472**

CLAIM NUMBER _____

DATE OF INJURY _____

❑ **ADDRESS ON APPLICATION IS NEW**

Injured Worker's Address		**Employer's Address**	
Name	Phone ( )	Name	Phone ( )
Address		Address	
City, State, Zip Code	County	City, State, Zip Code	County
Injured Worker's Representative		**Employer's Representative**	
Name	Phone ( )	Name	Phone ( )
Address		Address	
City, State, Zip Code	County	City, State, Zip Code	County

The undersigned attorney-at-law, duly authorized by the injured worker to represent him/her in the above captioned industrial claim, certifies that:

(1) I have rendered the following services for this claim which were necessary to obtain the award for which the advancement to pay the fee is requested:

_____

_____

_____

_____

_____

(2) Should the Application for Lump Sum Payment, now under consideration, be granted, the injured worker will not be liable for any further fee with respect to continuing compensation, except where a later dispute would arise in this claim, requiring my additional services.

(3) Should the Application for Lump Sum Payment include a request for reimbursement of expenses (not to exceed $1,000.00), a copy of the bill has been included with the application.

_____ _____
Attorney's Signature (required) Date

I, the undersigned injured worker, am making application for a lump sum advancement for payment of attorney fees in the amount of $_____. If the lump sum payment is granted by the Industrial Commission of Ohio, either wholly or in part, I request and authority is given to the Bureau of Workers' Compensation or self insuring employer to distribute the lump sum payment directly to the person or persons to whom payment is now due from me, pursuant to any Commission order. This payment will result in a reduction of weekly benefits from my ❑ Permanent Total ❑ Permanent Partial ❑ Death award.

I certify that the above facts on my application are true.

_____ _____
Injured Worker's Signature (required) Date