NEW YORK STATE Workers' Compensation Board

REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL
RFA-1LC

CASE INFORMATION

WCB Case ID	Date of Injury	Claim Admin Claim #
55555555	01/01/2020	555

Claimant Name Fake, Case

Claimant Counsel Name Jane Testing **Representative ID** [redacted]

Employer Name NYS WCB Fake Case Primary Employer

Insurer Name WCB Test Insurer Attn: Michael [redacted] **Insurer ID** [redacted]

Claim Admin Name WCB Test Insurer Attn: Michael [redacted] **Claim Admin ID** [redacted]

RFA-1LC SUMMARY

Summary of selected request reason(s):

1. Claimant is not working and not receiving payments

Additional proposed findings:

1. No additional proposed findings

RFA–1LC REQUEST DETAILS

1. Claimant is not working and not receiving payments

Medical documentation indicating disability is required.

Payment request: Payments were suspended and should be reinstated

From Date	To Date	Degree of Disability
10/01/2024	11/01/2024	10.00%

Is continuing payment requested? Yes

Is an expedited (45-day) hearing requested under WCL § 25(2)(a)? Yes, I affirm that a claim has been filed for a work-related injury; the employer is not paying wages; the claim has not been denied; there has not been a decision barring the claimant from compensation

SUPPORTING DOCUMENTATION

Referenced Document(s):

Form ID	Medical Service Date	Document ID	Received Date
ATTY-CORR		[redacted]	[redacted]

CERTIFICATION

The following request(s) require certification:

1. *Claimant is not working and not receiving payments*

I certify that I have discussed the reason(s) selected with the opposing party(ies) or its representative(s) and no settlement could be reached.

First Name	Last Name	Organization Name	Date
John	Tester	ABC LLC	10/30/2024

ATTESTATION

I affirm that:

(1) my statements are true and correct, and

(2) I am authorized to submit this request, and

(3) this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies), and

(4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

Claimant Counsel Name: Jane Testing **Date:** 11/01/2024

Phone Number: 5184570000 **Ext.:** 2325