

Certification of Readiness for Hearing and Request to Schedule a Hearing or Settlement Conference

Certification of Readiness by the applicant's representative is required before scheduling will begin. Failing to submit the Certification of Readiness may ultimately result in dismissal of the Application for Hearing.

Explanation:

- Submission of a Certification of Readiness (COR) by the applicant's representative is verification that the matter is ready for hearing or settlement conference. It is intended to allow for scheduling without the risk that the applicant will request an adjournment.
- The COR also is intended to encourage settlement discussions, resulting in earlier case resolution without the necessity of a scheduled hearing.

General Instructions:

- A copy of both pages of the COR, along with all supporting documentation must be sent to the insurer or self-insured employer or their attorney at the time it is filed with the Worker's Compensation Division (WCD).
- Do not submit a COR if the applicant believes that it may be necessary to implead additional parties.
- Do not submit a COR unless the WKC-16B or alternative medical report was previously submitted or it is included with the COR.
- The WCD will try to schedule the hearing at a location no more than 100 miles from the address of the employee or the employer unless the employee indicates a willingness to travel farther.
- In addition to the dates of unavailability for the attorney provided on this form, the attorney should continue to notify the WCD's calendar section of any future dates of unavailability.

Please note the following general guidelines for scheduling hearings:

- No postponements will be granted except under extraordinary circumstances. Difficulty in gathering medical proof **IS NOT** an extraordinary circumstance.
- Issues in addition to those listed on the COR form may be heard at the scheduled event if the notice and filing requirements in Wis. Stat. ch. 102 and Wis. Admin. Code ch. 80 are met or by stipulation of the parties.
- Unless waived by the parties, statutory filing deadlines apply. The applicant's representative is required to file all medical and vocational proof prior to submitting the Certification of Readiness.
- If the status or nature of the claim changes after the COR is filed and the employee is no longer ready to proceed, the applicant's representative must immediately notify the WCD in order to prevent scheduling of a hearing or settlement conference.

Insurer or self-insured employer instructions for objecting to the COR:

Any objection to the COR must be noted at the bottom of this form, filed with the WCD and a copy sent to the applicant's attorney, within 15 days of receipt of the COR. The specific reasons for the objection must be clearly stated, along with the additional time requested.

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The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

| | | | | | |
|-------------------------|--------------------------|--------------|--|---|--|
| Employee Name | Social Security Number | Claim Number | Date(s) of Injury: | | |
| | | | Is Date of Injury in Dispute? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Employee Street Address | City | State | Zip Code | Phone Number | |
| Employer Name: | City | State | Zip Code | Phone Number | |
| Street address: | | | | | |
| WC Carrier Name: | WC Carrier Contact Name: | | | Can Employee Travel more than 100 miles? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Address: | Phone Number: | | | | |

Indicate the event you wish to schedule: Formal Hearing OR Settlement Conference

ISSUES TO BE HEARD – PLEASE MARK THE APPROPRIATE BOXES BELOW

| | | |
|---|--|--|
| Average Weekly Wage (Claimed/Admitted) | Medical Causation? | Medical Expense? |
| <input type="checkbox"/> Yes \$ <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Estimate of Medical Bills: \$ |
| Order for Future Medical Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, explain the nature of the treatment at issue: |

| | |
|--|---|
| Temporary Total Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate the dates at issue below: | Temporary Partial Disability <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate the dates at issue below: |
|--|---|

| | |
|---|---|
| Permanent Partial Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Percentage Claimed and Body Part: Percentage Conceded and Body Part: | Loss of Earning Capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No Percentage Claimed: Percentage Conceded: |
|---|---|

Interpreter Needed? Yes No If Yes, language needed:

Other Issues Ready to be Heard (Specify in Detail)

| | | | | | |
|--------------------------|----------------|------|-------|----------|--------------|
| Employee's Attorney Name | Street Address | City | State | Zip Code | Phone Number |
| Insurer's Attorney Name | Street Address | City | State | Zip Code | Phone Number |
| Employer's Attorney Name | Street Address | City | State | Zip Code | Phone Number |

List all dates for which the attorney or representative will NOT be available in the next 90 Days

Certification: I, the undersigned Applicant's representative, attest that I am fully ready and prepared to proceed to a formal hearing or settlement conference as indicated for the issues identified above. I further attest the insurer's representative has either denied the claim(s) in full or has had at least 90 days' notice of the claimed issues in order to investigate. I believe this matter cannot be resolved without a formal hearing or settlement conference.

| | |
|--------------------------------|-------------|
| Applicant's Attorney Signature | Date Signed |
|--------------------------------|-------------|

Insurer's or Self-insured employer's objection to the COR (Must be Filed within 15 Days): If more space is needed, attach a separate statement setting forth specific reasons. See Page 1 for Instructions.

| | |
|--|-------------|
| Insurer or Self-Insured Employer Representative Name and Signature | Date Signed |
|--|-------------|