

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

FORM C-44

220 French Landing Drive, Ste. 1-B, Nashville, TN 37243-1002
Telephone: (615) 532-1309 or (615) 532-1471 Facsimile: (615) 253-5266
Send fax or email to ATTN: Administrative Review Email address: WC.Info@tn.gov



THIS FORM MUST BE RECEIVED WITHIN 7 CALENDAR DAYS OF RECEIPT OF SPECIALIST'S ORDER.

Request for Administrative Review of a Workers' Compensation Specialist's Order

Review Requested by: Employee, Employee's Attorney, Employer, Employer's Attorney, WC Insurance Carrier, WC Insurance Carrier's Attorney
Printed Name of Employee, Social Security Number of Employee, State File Number, Date of Injury, Printed Name of Employee's Attorney (if known), Printed Name of Employer, Printed Name of Claims Adjuster, Printed Name of Employer's/Carrier's Attorney (if known)

Date Order Issued, Date Order Received by Requesting Party, Name of WC Specialist Issuing Order, City Where Issuing Specialist Works

Order to be Reviewed is an: Order for Benefits, Order of Denial

Specifically, what aspect(s) of the decision made by the Workers' Compensation Specialist do you disagree with? For what reason(s)? (Must attach and timely supplement any and all documentation which supports your position.) Attach as many additional sheets as necessary.

Teleconferences must be scheduled within ten (10) calendar days of the receipt of this request form by the Administrative Review office. Please list your availability for the next ten days (Please list the time zone for which the times are given):

Person within your office to contact regarding the scheduling of this matter:

By my signature below, I hereby certify that I have (1.) provided notice by telephone AND (2.) provided a true and correct copy of this Request for Administrative Review of a Workers' Compensation Specialist's Order and all supporting documentation and information attached hereto to the opposing party and/or counsel for the opposing party by facsimile, e-mail, and/or regular mail.

PRINTED NAME OF REQUESTING PARTY, PHONE (INCL. AREA CODE), SIGNATURE OF REQUESTING PARTY, DATE, EMAIL ADDRESS OF REQUESTING PARTY, FAX

Printed Address of Requesting Party: Company/Firm Name (if applicable), Street Address, City, State and Zip Code

A Copy of Workers' Compensation Specialist's Order to be reviewed must be attached.