

**ILLINOIS WORKERS' COMPENSATION COMMISSION
 PETITION FOR REVIEW OF ARBITRATION DECISION
 UNDER SECTION 19(b-1) OF THE ACT**

Please file two copies of this form.

Case # _____ WC _____

 Employee/Petitioner
 v.

 Employer/Respondent

The petitioner ____ respondent ____ requests the Commission to review the arbitration decision for this case, filed on _____ and received on _____, and to take the following steps:

1. Furnish _____ transcripts of the arbitration hearings regarding the Section 19(b-1) petition, including all exhibits. The transcript was ____ was not ____ ordered at arbitration. I have paid \$ _____ to the court reporter and enclose a copy of the check. I guarantee payment for the cost to prepare and copy the transcripts, even if I withdraw this appeal, within 30 days from the court reporter's written request, and enter myself as surety therefor.
2. Consider the issues checked below to which I take exception:

ACCIDENT

- Did it occur?
- Did it arise out of employment?
- Was it in the course of employment?
- Is the date correct?

BENEFIT RATES

- Are the benefit rates correct?
- Are the wage calculations correct?

EMPLOYMENT

- Was there an employer-employee relationship?

JURISDICTION

- Does the Commission have jurisdiction?

MEDICAL EXPENSES

- Is there a causal connection?
- Is the charge reasonable?
- Was the treatment reasonably necessary?
- Is prospective medical care necessary?

NOTICE

- Was the respondent given proper notice?

OCCUPATIONAL DISEASE

- Was there an exposure?
- Was there a disease?
- Did it arise out of employment?
- Was it in the course of employment?
- What was the last date of exposure?

OTHER (explain) _____

PENALTIES AND FEES

- Section 16
- Section 19(k)
- Section 19(l)

STATUTE OF LIMITATIONS

- Was the case filed within the statute of limitations?

TEMPORARY DISABILITY

- Is there a causal connection?
- Is the duration of the disability correct?

I offer the following testimony or exhibits to support my petition: (Cite page/exhibit #, legal references, etc.)

 Signature Telephone number

 Street address

 Name (please print; attorneys, include IC attorney code#)

 City, State, Zip code

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, _____, affirm that I delivered _____ sent by certified mail (return receipt requested) _____
a copy of this form
at _____ on _____ to each party at the address(es) listed below.

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public