

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION  WC-376i (r. 3/19/13)	<b>ORDER FOR          TOTAL DISABILITY          w/Second Injury Fund</b>	CASE NO'S.:  VICINAGE:
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<b>PETITIONER</b>	SOCIAL SECURITY NUMBER: _____ DOB: _____ NAME: _____ GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE      MEDICARE ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO ADDRESS (Including County): _____	<b>ATTORNEY FOR PETITIONER</b>	<input type="checkbox"/> SSN <input type="checkbox"/> FEDERAL EMPLOYER NUMBER <input type="checkbox"/> NJ REG NUMBER NAME: _____ ADDRESS: _____ TELEPHONE NUMBER (AREA CODE): _____ APPEARING: _____
<b>vs</b>			
<b>RESPONDENT</b>	NAME: _____ ADDRESS (Including County): _____	<b>INSURANCE CARRIER</b>	NAME _____ <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> TPA CLAIM NUMBER: _____ DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE: _____ DESCRIBE (Briefly): _____  FUND PETITION FILE DATE: _____
<b>ATTORNEY FOR RESPONDENT</b>	NAME: _____ ADDRESS: _____ TELEPHONE NUMBER (AREA CODE): _____ APPEARING: _____ APPEARING FOR SECOND INJURY FUND: _____		

**Upon the proofs presented and the stipulations made, I find and determine the following facts:**

**LAST COMPENSABLE ACCIDENT OR EXPOSURE**

WAGES: _____	RATE: _____	Date of last payment of Permanent Compensation by Respondent: _____
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In accordance with the provisions of the New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.), I find as follows:

Petitioner is totally and permanently disabled as of \_\_\_\_\_

**Permanent Disability payable by Respondent (Describe Percentages, Nature and extent of Disability, and Members involved):**



State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION  WC-376i	<b>ORDER FOR          TOTAL DISABILITY          w/Second Injury Fund - Page 3</b>	CASE NO'S.:  VICINAGE:
--	---	------------------------------

The first \_\_\_\_\_ weeks of permanent disability are to be paid at the full rate of \$ \_\_\_\_\_ reflecting Petitioner's share of counsel fee and costs.

An Application for Social Security Disability Benefits and / or Government Ordinary Disability Pension  is pending  is on appeal  has not been filed. Should Petitioner be awarded Social Security Disability Benefits and / or Government Ordinary Disability Pension, Petitioner shall immediately notify the Respondent and the Second Injury Fund of this award. The Petitioner shall reimburse the Respondent and the Second Injury Fund for any workers' compensation benefits paid to Petitioner in excess of the offset rate during the period of time Petitioner has received Social Security Disability benefits or Government Ordinary Disability Pension.

In the event there is a change in the number or status of the auxiliary beneficiaries while Petitioner is receiving Workers' Compensation benefits, Petitioner shall immediately notify the Respondent.

I further Order that Respondent furnish the Petitioner such medical attention, prosthesis, and medical supplies as the condition of the Petitioner may require. Should any emergency arise, necessitating immediate medical attention for the Petitioner, notice and request to Respondent shall not be necessary.

Respondent authorizes \_\_\_\_\_ as treating physician.

The date of Petitioner's Permanent Total disability is \_\_\_\_\_.

On \_\_\_\_\_, which is the expiration of the 450 week period, benefits to continue in accordance with the provision of N.J.S.A. 34:15-12(b) as amended.

Pursuant to N.J.S.A. 34:15-12(b), petitioner will be referred to the Division of Vocational Rehabilitation Services for evaluation and services prior to the expiration of 450 weeks from the date of Total Permanent Disability.

**PETITIONER DATA**

Date of Last Employment:	Occupation:	Gross Weekly Wages:
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**PRE-EXISTING COMPENSABLE DISABILITIES**

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION  WC-376i	<b>ORDER FOR          TOTAL DISABILITY          w/Second Injury Fund - Page 4</b>	CASE NO'S.:  VICINAGE:
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Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

**(Provide like data on additional sheets as required)**

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION  WC-376i	<b>ORDER FOR          TOTAL DISABILITY          w/Second Injury Fund - Page 5</b>	CASE NO'S.:  VICINAGE:
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**PRE-EXISTING NON-COMPENSABLE DISABILITIES**

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

Date of Onset:	Origin (if known): <input type="checkbox"/> Congenital <input type="checkbox"/> Accident / Injury
Description:	

**(Provide like data on additional sheets as required)**

State of New Jersey  
Department of Labor and Workforce Development  
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WC-376i

**ORDER FOR  
TOTAL DISABILITY  
w/Second Injury Fund - Page 6**

CASE NO'S.:

VICINAGE:

**PETITIONER DATA**

Education (highest level completed):

Special Occupational Skills:

Rehabilitation Potential:

Third Party Actions:

If third party liability action is pending, provide the name and address of the attorney representing this petitioner if different than the workers' compensation attorney, the defense attorney(s), the case name and docket number.

**(Respondent and Second Injury Fund reserve their rights under N.J.S.A. 34:15-40)**

REMARKS:



