

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-374i (3/19/13)	ORDER FOR TOTAL DISABILITY	CASE NO.'S.: VICINAGE:
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PETITIONER	SOCIAL SECURITY NUMBER: NAME: DATE OF BIRTH: MEDICARE ELIGIBLE: <input type="checkbox"/> YES <input type="checkbox"/> NO ADDRESS (Including County):	ATTORNEY FOR PETITIONER	<input type="checkbox"/> SSN <input type="checkbox"/> FEDERAL EMPLOYER NUMBER <input type="checkbox"/> NJ REG NUMBER NAME: ADDRESS: TELEPHONE NUMBER (AREA CODE): APPEARING:
vs			
RESPONDENT	NAME: ADDRESS (Including County):	INSURANCE CARRIER	NAME : <input type="checkbox"/> SELF-INSURED <input type="checkbox"/> TPA CLAIM NUMBER: DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE: DESCRIBE (Briefly):
ATTORNEY FOR RESPONDENT	NAME: ADDRESS: TELEPHONE NUMBER (AREA CODE): APPEARING:		

Weekly Wages: \$	Rate(s): \$ / \$
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IF RE-OPENED PETITION, INDICATE FOR LAST AWARD: **DATE:** _____
PERMANENT: \$ _____ **TEMP:** \$ _____

This matter having come before the COURT on this _____ day of _____, _____ :

- ORDER FOR JUDGMENT**
 It appearing that the Petitioner suffered a compensable injury on the above mentioned date while in the employ of respondent;
 It is Ordered and Adjudged that Petitioner be awarded compensation benefits, payable as set forth below.
- ORDER APPROVING SETTLEMENT**
 The parties having settled the matter and a finding by the Court having been made that the terms of the settlement are fair and just;
 It is Ordered that this settlement be approved and the petitioner be paid as set forth below.

PERMANENT DISABILITY:

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TEMPORARY: _____ Weeks at \$ _____ = \$ _____ less \$ _____ paid = Balance due \$ _____
PERMANENT: _____ Weeks at \$ _____ = \$ _____ less \$ _____ paid = Balance due \$ _____
 Voluntary Tender Reopener Credit

MEDICAL BILLS (Doctors and/or Institutions):

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 of this award. The Petitioner shall reimburse the Respondent for any workers' compensation benefits paid to Petitioner in excess of the statutory 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.

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	REIMBURSE	TAX IDENTIFICATION NUMBER	TOTAL AMT. ALLOWED	PAYABLE BY PETITIONER	PAYABLE BY RESPONDENT
MEDICAL FEE ALLOWED: <i>(expert and/or testimonial)</i>					
ATTORNEY(S) FEE:					
STENOGRAPHIC SERVICE:					
MISCELLANEOUS FEES: <i>(fill in below)</i>					

ORDER FOR CHILD SUPPORT
 ADDENDUM ATTACHED

MEDICARE ELIGIBILITY: PETITIONER <input type="checkbox"/> IS) (<input type="checkbox"/> IS NOT) ELIGIBLE FOR MEDICARE

_____ DATE
 JUDGE OF COMPENSATION

WE HEREBY CONSENT TO THE ENTRY AND FORM OF THIS ORDER AND ACKNOWLEDGE RECEIPT OF COPY:

 Petitioner's Attorney

 Respondent's Attorney

 Petitioner (where applicable)

