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:

PETITIONER

SOCIAL SECURITY NUMBER:

NAME:

DATE OF BIRTH:

MEDICARE ELIGIBLE: ☐ YES ☐ NO

ADDRESS (Including County):

vs

RESPONDENT

NAME:

ADDRESS (Including County):

ATTORNEY FOR RESPONDENT

NAME:

ADDRESS:

TELEPHONE NUMBER (AREA CODE):

APPEARING:

ATTORNEY FOR PETITIONER

☐ SSN ☐ FEDERAL EMPLOYER NUMBER ☐ NJ REG NUMBER

NAME::

ADDRESS:

TELEPHONE NUMBER (AREA CODE):

APPEARING:

INSURANCE CARRIER

NAME : ☐ SELF-INSURED ☐ TPA

CLAIM NUMBER;

DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE:

DESCRIBE (Briefly):

Weekly Wages: $ **Rate(s): $ / $**

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:

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-374i (3/19/13)	**ORDER FOR TOTAL DISABILITY** **Page 2**	CASE NO'S.: VICINAGE:

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.

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-374i (3/19/13)	**ORDER FOR TOTAL DISABILITY** **Page 3**	CASE NO'S.: VICINAGE:

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

☐ **ORDER FOR CHILD SUPPORT** ☐ **ADDENDUM ATTACHED**

MEDICARE ELIGIBILITY: PETITIONER (☐ IS) (☐ 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)

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-168 r. 8/27/2015	**CASE EXHIBIT LISTING** **FOR: ☐ PETITIONER ☐ RESPONDENT**	CASE NO'S.: VICINAGE:

Judge: _____

Petitioner: _____ **Respondent**: _____

Petitioner Attorney: _____ **Respondent Attorney**: _____

					Retained		
Hearing Date	***No.***	***ID***	***Ev.***	***Description***	***Court***	***Atty.***	***Reporter***
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	