# REQUEST FOR ASSISTANCE

State Form 45442 (R2 / 5-06)

**INDIANA WORKER'S COMPENSATION BOARD**
**OMBUDSMAN DIVISION**
402 West Washington Street, Room W196
Indianapolis, Indiana 46204
Telephone: (317) 232-3808
Toll free: (800) 824-COMP

*INSTRUCTIONS:* *1. Please print or type*
*2. Return completed request to the address listed at right.*

| EMPLOYEE INFORMATION | EMPLOYER INFORMATION |
|---|---|
| Name of employee | Name of employer |
| Address (*number and street*) | Address (*number and street*) |
| City, state, and ZIP code | City, state, and ZIP code |
| Telephone number<br>( ) | Telephone number<br>( ) |
| Social Security number * | County of employment |
| Date of birth (*month, day, year*) | WORKER'S COMPENSATION INSURANCE COMPANY INFORMATION |
| Date of accident (*month, day, year*) | Name of company |
| Nature of injury: | Address (*number and street*) |
| Have you hired an attorney? ** | City, state, and ZIP code |
| If Yes, name and telephone number of attorney | Telephone number<br>( ) |
| | Contact person(s) |

Briefly describe your complaint / dispute (*attach additional sheets if necessary*):

I hereby request the Ombudsman Division of the Worker's Compensation Board to investigate my complaint. I understand that the Ombudsman Division is not a replacement for legal counsel, and that any specific legal questions should be addressed to my attorney.

| Signature of employee | Date (*month, day, year*) |
|---|---|
| | |

* PRIVACY NOTICE: This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

** You have no obligation to employ legal counsel under the Indiana Worker's Compensation and Occupational Diseases Acts.