State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC(DO)-100 Generic i (r.8/14/09)	**ORDER**	CASE NO'S.: VICINAGE:

PETITIONER

NAME:

DATE OF BIRTH: | MEDICARE ELIGIBLE: ☐ YES ☐ NO

ADDRESS:

vs

RESPONDENT

NAME:

ADDRESS:

ATTORNEY FOR RESPONDENT

NAME:

ADDRESS:

TELEPHONE NUMBER (AREA CODE):

APPEARING:

ATTORNEY FOR PETITIONER

FEDERAL EMPLOYER NUMBER

NAME:

ADDRESS:

TELEPHONE NUMBER (AREA CODE):

APPEARING:

INSURANCE CARRIER

NAME ☐ SELF-INSURED ☐ TPA

ADDRESS:

CLAIM NUMBER:

DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE:

DESCRIBE (Briefly):

This matter having come before the COURT on this _____ day of _____ , _____
IT IS ORDERED

ALLOWANCES	**REIMBURSE**	**TAX IDENTIFICATION NUMBER**	**TOTAL AMT. ALLOWED**	**PAYABLE BY PETITIONER**	**PAYABLE BY RESPONDENT**
MEDICAL FEE ALLOWED: ***(report and/or testimony)***					
ATTORNEY(S) FEE:					
STENOGRAPHIC SERVICE:					

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

PETITIONER'S ATTORNEY

PETITIONER (where applicable)

RESPONDENT'S ATTORNEY

JUDGE OF COMPENSATION DATE

JUDGE'S NAME

THE ORIGINAL OF THIS DOCUMENT, SIGNED BY THE JUDGE OF COMPENSATION, WILL BE MAINTAINED ON FILE IN THE DIVISION OF WORKERS' COMPENSATION, PURSUANT TO N.J.S.A. 34:15-121 et. seq.