State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-100 (r. 8/27/2015)	**ORDER** ☐ **JUDGMENT** ☐ **APPROVING SETTLEMENT**	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 ☐ RESPONDENT IS SELF-INSURED ☐ TPA

ADDRESS:

CLAIM NUMBER:

DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE:

DESCRIBE (Briefly):

ADMINISTRATIVE DISMISSALS
(List Other Insurance Carriers to be dismissed from case, without prejudice):

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

IF RE-OPENED PETITION, INDICATE FOR LAST AWARD:

Date: _____ **Award:** _____ **Permanent Paid:** $ _____ **Temporary Paid:** $ _____

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 indicated on Page 2.

☐ **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 indicated on page 2.

PERMANENT DISABILITY (Describe Percentages below followed by the Nature and Extent of Injury and Members involved):

% of

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DISABILITY AWARDED:

TEMPORARY: _____ weeks at $ _____ = $ _____ less $ _____ paid = Balance due $ _____

PERMANENT: _____ weeks at $ _____ = $ _____ less $ _____ paid = Balance due $ _____

Credits: ☐ Bonafide Voluntary Tender ☐ Non Bonafide Voluntary Tender ☐ Reopener Credit ☐ N.J.S.A. 34:15-40 ☐ _____

MEDICAL BILLS (Doctors and/or Institutions) AND/OR MISCELLANEOUS INFORMATION:

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

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

☐ **The Court finds the parties adequately considered Medicare interest, be that as it may, should a Medicare issue arise, this Court retains jurisdiction.**

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

THE COURT FINDS THIS SETTLEMENT FAIR AND JUST.

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.

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***
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