

Application for Determination or Increase of Percentage of Permanent Partial Disability (C-92)

Claim number			

Instructions

Complete this form and fax it to 1-866-336-8352, or send it to your local BWC claims office.									
Injured worker information									
Name					Date of injur	У			
Address Preferred method of con									
						phone L Email L Mail			
City		St	ate		ZIP code				
Home phone number	Cell phone number	Dr	rimary email ad	Idrocc					
		' '	illiary ciriali ac	iui 033					
Application designation									
I am applying for one of the optic	ons listed below.								
☐ The initial percentage of permanent partial disability (%PPD) — I understand I must attend a BWC exam, and that BWC will evaluate all the									
conditions allowed in my claim.									
☐ A %PPD for a newly allowed condition in this claim — I understand if an exam is scheduled, I am required to attend.									
Please list newly allowed con		— i understand	ili ali exalli is	s scrieduled, i a	iii required	to atteria.			
r reace not nowly anowed con	altion(o) note.								
☐ Increase in the %PPD — I believe my medical condition has worsened, and my %PPD for this claim has increased. I understand I									
	,		,						
am required to submit with this application a medical report from my doctor showing evidence of an increase. I understand BWC will only consider an increase for those conditions supported by evidence of new and changed circumstances. I understand if an exam									
is scheduled, I am required to		ftornoons (12 n	m to Enm						
Exam availability: Mornings We will attempt to accommoda:					dismiss this	s application if the injured			
worker fails to respond to an atte									
Please check all days of the we	•								
Monday Tuesday	Wednesday	Thursda		riday	Sature	day			
☐ Morning ☐ Morn	_	_	1orning	☐ Morning	□ Ar	nytime			
	noon $oxdot$ Afterno		fternoon	Afternoo	^	Appointments on this day			
☐ Anytime ☐ Anyti	ime \square Anytim	ne ∐ A	nytime	☐ Anytime		ailable on a limited basis.			
• If there are specific dates yo	u cannot attend an ex	amination in the	e next six wee	eks, please list	them belov	w.			
• If you are only available before	ore/after a specific time	e of day (mornir	ng or afternoo	on), please not	e that time	(e.g., only after 3 p.m.).			
	·								
Charle have if you need an inter	rorator to attend the aver								
Check here if you need an interpreter to attend the exam.									
Injured worker signature	Maia farma ia turca an					de els caralisas a falas			
I certify the information on statement, misrepresentate									
statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits/compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not									
entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or									
imprisonment or both.									
I certify all the information			me of the fili	ing of this app	olication.				
Signature of injured worker/injure	d worker representativ	ve .				Date			
Authorizad toward									
Authorized to receive workers' compensation check Injured worker representative name Representative ID number									
Injured worker representative name			Representat	ive ID number					
The makes and the state DMO to mail directly to make the state of the									
I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim any accrued monotony award generated by this application.									
 accrued monetary award generated by this application. This authorization does not give my attorney the authority to cash or endorse a check on my behalf. 									
 This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there 									
is a subsequent hearing, appeal or reconsideration after payment was made.									
This authorization is not valid if it is filed beyond 18 months from the date of my signature.									
Signature of injured worker						Date			