

insurer name, address, and phone:

Notice of Closure: Own Motion Claim

Pursuant to ORS 656.278(6)

Worker:

Mailing date:
WCD file no.:
Date of injury:
Date of Own Motion reopening:
Insurer's claim no.:

This is to advise you that your Own Motion workers' compensation claim is now closed. As your insurer, we have reviewed medical and other information about your *accepted condition(s)* and have determined the extent of your disability. This closure applies to the most recent reopening(s) of your Own Motion claim pursuant to ORS 656.278.

Your claim was reopened for:

<input type="checkbox"/>	A. "Post-aggravation rights" "worsened condition" claim. ORS 656.278(1)(a).	List "post-aggravation rights" worsened condition(s) for which claim was reopened:
<input type="checkbox"/>	B. "Post-aggravation rights" new or omitted medical condition claim. ORS 656.278(1)(b).	List "post-aggravation rights" new/omitted medical conditions for which claim was reopened:
<input type="checkbox"/>	C. Pre-1966 Injury "medical services" claim. ORS 656.278(1)(c). Pre-1966 claims involving "post-aggravation rights" "worsened conditions" or new or omitted medical conditions are included in boxes "A" and "B," respectively.	List medical services for which claim was reopened:

Medically stationary date:

In accordance with OAR 438-012-0055, you were entitled to time-loss compensation for the following period(s):	Temporary disability compensation paid: \$ _____
In accordance with ORS 656.278(1)(b), (2)(d), and as summarized below and calculated on the attached closure worksheet (Form 440-2807), you are provided the following permanent disability benefits for your compensable "post-aggravation rights" new/omitted medical condition(s):	Permanent disability compensation awarded by this closure: \$ _____

Note: If you disagree with the impairment findings used to determine permanent disability, you may request the appointment of a medical arbiter with your request for Workers' Compensation Board review under the following paragraph.

NOTICE TO WORKER

If you think this claim closure is wrong, you may ask the Workers' Compensation Board to review it and decide whether you are entitled to more compensation. If you do not ask for review within 60 days of the date of this notice, you will lose any right you may have to contest this notice unless you can show good cause for delay beyond 60 days. After 180 days, all rights will be lost. You may ask for a review by writing to the Workers' Compensation Board, 2601 25th St., Ste. 150, Salem, Oregon 97302-1280. You may have an attorney of your choice, whose fee will be limited to a percentage of any more compensation you may be awarded. (OAR 438-012-0055)

Authorized representative: (Please type name):

Distribution (one copy each to):

- Worker
- Worker's representative (if any)
- Workers' Compensation Division
- Insurer

By: _____
Signature *Date*

This is an important document. Keep it in a safe place.