Complete and use the button at the end to print for mailing.

SD EForm - 1657 V1 HELP

Instructions for Completing the Petition for Hearing

Please refer to this page as you complete the Petition for Hearing. Please print or type your responses in the blanks provided. If you need to add any information, you may attach a separate page to the Petition for Hearing.

Each blank space on the petition is numbered. The following list identifies the information needed in each space. Please be as specific as possible. **You** are the claimant.

1. Your full name
2. The name of your employer where you were injured
3. The name of the insurance company providing workers' compensation coverage for your employer
4. Your full name
5. The date of your injury
6. The month of your injury
7. The year of your injury
8. The name of your employer where you were injured
9. The city or town where you were injured
10. The date of your injury
11. The month of your injury
12. The year of your injury
13. The name of your employer where you were injured
14. State the body part that was injured. For example, if you injured your back, write "his back" in the space, or "her hand" if you injured your hand. If you injured more than one body part, please list all the body parts injured.
15. Describe in as much detail as possible how you were injured.
16. Describe in as much detail as possible any disabilities you claim as a result of your injury.
17. The date you signed the petition for hearing
18. Your full name, mailing address, phone number and Social Security number

SD DEPARTMENT OF LABOR AND REGULATION
DIVISION OF LABOR AND MANAGEMENT

1)_____ ,

Claimant,

PETITION FOR HEARING

vs.

2)_____,

Employer,

and

3)_____,

Insurer.

COMES NOW, 4)_____ , Claimant in the above matter, respectfully shows and alleges as follows:

I.

That on or about the 5) _____ day of 6)_____ 7) _____, and for some time prior thereto, Claimant was employed by 8) _____ in 9) _____, South Dakota.

II.

That the Employer was insured on the date of injury listed below under the Workers' Compensation laws of the State of South Dakota with the Insurer above named.

III.

That on or about the 10) _____ day of 11) _____ 12) _____ , while Claimant was employed by 13) _____, Claimant suffered an injury to 14)_____, all of which arose out of and in the course of his or her employment with said Employer, in the manner following:

15)

IV.

That thereafter and within less than three (3) days after the injury the Employer had actual knowledge of Claimant's injury.

V.

That the injury described above has caused Claimant to suffer the following disability or disabilities:

16)

WHEREFORE, Claimant requests that a hearing be had on the claim and that upon such hearing an award of workers' compensation benefits be made for any and all benefits to which Claimant is entitled under the South Dakota Workers' Compensation Act.

17) Dated this _____ day of _____, _____ .

18) Information from person submitting this Petition for Hearing:

Name: _____

Mailing Address: _____

_____ _____ _____

Phone Number: _____

Social Security Number: _____

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