Department of Workforce Development

Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

COMPROMISE REVIEW APPLICATION

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

WC Claim Number	Applicant Name
Social Security Number*	Applicant Mailing Address
Injury Date	Applicant Attorney Name (if any)
Applicant Attorney Mailing Address (if any)	
Employer Name	Insurance Company Name
Employer Mailing Address	
Employer Name (if more than one)	Insurance Company Name
Employer Mailing Address (if more than one)	
Briefly describe how injury occurred:	
Nature of Disability: (Indicate part of body injured and kind of disability as either strain or fracture)	
Date the order affirming the compromise was issued: _____	
List all reasons why the applicant feels compromise settlement was unjust:	
Where should hearing be scheduled?	
I will be ready for full hearing at any time after the following date: _____ /_____ /_____ If not fully prepared for hearing, state reason here:	
Applicant Signature	Date Signed

If it is claimed that greater disability has resulted than was anticipated at the time of settlement, application should be accompanied by physician's report, stating the extent of disability claimed.