



Tennessee Bureau of Workers' Compensation

220 French Landing Drive,
1-B Nashville, TN 37243-1002

Phone: **800-332-2667** Fax: **615-253-5266** Email: **WC.AdminReview@tn.gov**

FORM C-44

REQUEST FOR ADMINISTRATIVE REVIEW OF A WORKERS' COMPENSATION SPECIALIST'S ORDER

Requests for review must be received by the Bureau within **seven calendar days** of receipt of the Specialist's Order. Please submit a **copy of the Order** with this request.

Requesting Party: Employee Employee's Atty. Employer/Carrier Employer's/Carrier Atty.

Employee's Name _____ State File # _____

Employee's Attorney's Name _____

Employer's Name _____ Adjuster's Name _____

Employer/Carrier Attorney's Name _____

Date Order issued _____ Date Order received _____ Date of Injury _____

Name of WC Specialist _____

What specific aspects of the Order issued by the WC Specialist do you disagree with, and why? _____

Name of Opposing Party _____ Email _____

Teleconferences must be scheduled within ten calendar days of the receipt of this request unless waived by the parties. Please list your availability for the next ten days and provide the time zone for each time given.

Contact name for scheduling: _____ Email _____

Name of Requesting Party _____ Phone _____

Company/Practice Name _____

Business Address _____ Phone _____

Address 2 _____ Fax _____

City _____ State _____ ZIP _____ Email _____

By my signature below, I hereby certify that I have provided a true and completed copy of this form and all supporting documentation attached hereto to the opposing party and/or counsel for the opposing party.

Signature _____ Date _____