STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-77 APPLICATION FOR HEARING

Instructions

Please completely fill out the WC-77 APPLICATION FOR HEARING FORM.

Completion of this form will expedite resolution of issues of controversy in a fair and judicious manner.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Department of Labor and Industrial Relations, Disability Compensation Division

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakekua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

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FORM WC-77 APPLICATION FOR HEARING

Name of Applicant	
Address	
Telephone No. ( )	Representing

_____)
_____)
_____)
(Claimant Name and Address))
)
Claimant,)
)
vs.)
)
_____)
_____)
_____)
(Employer/Carrier))
)
)
)
)
)
_____)

Case No. _____

Date of Injury _____

APPLICATION FOR HEARING

I, _____, above-named applicant, hereby request that a hearing be scheduled on this matter on the issue(s) as noted below:

1. SUMMARY

Provide an explanation of the issue(s) in dispute: 1) Why you were unable to resolve the dispute, and 2) The remedy or award you are seeking.

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2. STATEMENT OF THE ISSUE(S) TO BE DETERMINED AT THE HEARING [Check Applicable Space(s)]

☐ REVIEW OF EMPLOYER'S DENIAL OF HEALTH CARE. Attach the Treatment Plan. If not available, please attach a letter of explanation (Cost Review).

☐ COMPENSABILITY issues pursuant to §386-3, Hawaii Revised Statutes (HRS). Please attach Form WC-1 and/or Form WC-5.

☐ TERMINATION OF TEMPORARY TOTAL DISABILITY issues pursuant to §386-31(b), HRS. Attach termination letter and any disability certifications.

☐ TERMINATION OF TEMPORARY PARTIAL DISABILITY issues pursuant to §386-32(b), HRS.

☐ PERMANENT DISABILITY issues pursuant to §§386-31 and 386-32, HRS. Attach a copy of the rating report(s).

☐ DISFIGUREMENT pursuant to §386-32, HRS.

☐ DEPENDENT DEATH BENEFITS pursuant to §386-41, HRS. Please attach Form WC-5A, Death Certificate, and all relevant marriage and birth certificates.

☐ CONCURRENT EMPLOYMENT benefits pursuant to §386-51.5, HRS. Please attach Form WC-14. Send copy of this request to the appropriate office as listed on the Instruction Sheet.

☐ REOPENING pursuant to §386-89, HRS. Please attach relevant medical reports.

☐ OTHER ISSUES. Please identify all other issues to be resolved at the hearing and attach any other supporting documentation:

3. WITNESSES

Please list name(s) and address(es) of all witness(es) to be presented at the hearing and/or those whose testimony will be submitted via a deposition transcript. In the interest of justice and fairness, failure to list the names of witness(es) and/or those whose testimony will be submitted via a deposition transcript may preclude witnesses from testifying at the hearing and/or submitting a deposition transcript.

Name	Work Phone ( )	Home Phone ( )
Address		

Name	Work Phone ( )	Home Phone ( )
Address		

Name	Work Phone ( )	Home Phone ( )
Address		

If necessary, please list any additional names, phone numbers and addresses of witnesses on a separate sheet.

4. SPECIAL ACCOMMODATIONS

Are there any unusual, emergency or extenuating conditions that you would like the Department to consider in calendaring this case for a hearing? If yes, please briefly explain below:

(Date) (Signature of Applicant)

5. NOTICE TO RECEIVING PARTIES:

YOU HAVE THE RIGHT TO FILE A RESPONSE TO THIS APPLICATION. YOU MUST FILE YOUR RESPONSE ON THE FORM "RESPONSE TO APPLICATION FOR HEARING" (FORM WC-77A) AT WWW.HAWAII.GOV/LABOR.

OFFICE USE ONLY

Your request for a hearing has been denied for the following reason(s):

☐ Lack of medical evidence.

☐ Issue is not within the Department's jurisdiction.

☐ Other:

(Date) (Hearings Review Section)

Auxiliary aids and services are available upon request. Please call: (808) 586-9161; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.