



W.C.C. # of pending petitions:

\_\_\_\_\_

\_\_\_\_\_

**State of Rhode Island and Providence Plantations**  
**Providence, S.C.** **Workers' Compensation Court**

\_\_\_\_\_  
Name of Employer-Petitioner

W.C.C. # \_\_\_\_\_

\_\_\_\_\_  
Name of Employee-Respondent

XXX-XX-  
\_\_\_\_\_  
Social Security Number (last 4 digits only)

\_\_\_\_\_  
Address of Employee

\_\_\_\_\_

\_\_\_\_\_  
Insurance Carrier

**Employer's Petition to Review and/or Amend Agreement or Decree Concerning Compensation**

The undersigned EMPLOYER hereby petitions for a determination of its rights under a compensation agreement or decree of the Workers' Compensation Court. **A copy of said agreement or decree establishing the liability of the employer to pay workers' compensation benefits is filed herewith.** In support of this petition, the employer or its counsel affirms that the employer has fully complied with all outstanding agreements and orders to date and alleges as follows:

- 1. The employee has returned to work at an average weekly wage equal to or in excess of that which he/she was earning at the time of his/her injury. A wage transcript in support of this allegation is attached.
- 2. The employee's incapacity for work has ended.
- 3. The employee is able to return to light select work.
- 4. The employee has reached maximum medical improvement.
- 5. The employer seeks a reduction in the employee's weekly benefits pursuant to R.I.G.L. § 28-33-18(b).
- 6. The employee obstructed or refused to submit to a medical examination as provided for in R.I.G.L. Chapters 29 to 38 inclusive.
- 7. The employee's weekly compensation payments have been based upon an erroneous average weekly wage. The average weekly wage at the time of the employee's injury was \$ \_\_\_\_\_.
- 8. The employee is subject to a reduction in benefits pursuant to R.I.G.L. § 28-33-18(c).
- 9. The employer requests an Anniversary Review pursuant to R.I.G.L. § 28-33-46.
- 10. The employer requests that the employee be referred to the Dr. John E. Donley Rehabilitation Center for \_\_\_\_\_.
- 11. The employee has refused an offer of suitable alternative employment.
- 12. Other reason for review (please specify).  
\_\_\_\_\_.

**Name, Address, Phone Number and Bar Registration Number of Attorney for Petitioner**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Petitioner

\_\_\_\_\_  
Date

File the original and three copies with the appropriate attachments with the Office of the Administrator of the Workers' Compensation Court, J. Joseph Garrahy Judicial Complex, One Dorrance Plaza, Providence, Rhode Island 02903-3973.

Distribution: White: Court Yellow: Employee Pink: Employer