KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

APPLICATION FOR POST AWARD MEDICAL, TERMINATION OR MODIFICATION OF MEDICAL BENEFITS

K-WC E-4 Pro Se (Rev. 11-18) (K.S.A. 44-510k)

DO NOT WRITE IN THIS SPACE

Date Stamp

Case number *(required)*: _____

Employee: _____
First Middle Last

Phone: _____

Email: _____

Employer: _____

Applicant applies for post award medical, termination or modification of medical benefits authorized by the decision entered on: _____.
(Date of award or order)

1. Briefly state the purpose for this application: _____

2. Have the parties met and conferred prior to the scheduled hearing? ☐ YES ☐ NO (K.S.A. 44-510k(b))

3. Are you interested in going through the Workers Compensation mediation process? ☐ YES ☐ NO

DO NOT USE THIS FORM IF YOU ARE AN ATTORNEY OR HAVE AN ATTORNEY

By completing this form and submitting it to the Division, you certify that you are not represented by an attorney for the matter referenced herein.

_____ _____ _____
Applicant printed name *Signature* *Date*

Address: _____

DO NOT WRITE IN THIS SPACE

Certified Stamp ALJ Copy

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that Social Security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of Social Security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the Social Security number.