

FORM I

[See rule (3)]

Appeal to Employees' Insurance Court

To,

Employees' Insurance Court,

..... (Address)

Insurance No:

I, ... (full name of appellant) of
.....(Address of appellant) appeal against the decision on.....(date) of the Medical Board/Medical
Appeal Tribunal at.....(Address) notified to me by letter (from) to be treated as temporary and the next date
when the case should be referred to the Medical Board is..... ; or (3) the disablement can be declared to be
of permanent nature and (i) the extent of loss of earning capacity can be assessed provisionally or finally; (ii) the
assessment of the proportion of loss of earning capacity whether provisional or final; and (iii) in case of provisional
assessment, the period for which such assessment shall hold good. The following are the grounds of my appeal:-

List of documents, if any.

Date.....

Signature or thumb impression of appellant.

The statement of facts contained in this application is, to the best of my knowledge and belief, true and correct.

Date

Signature or thumb impression of appellant.

Signature of an Attester in case the person is
not able to sign and affixes thumb
impression.