MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

ENTRY OF APPEARANCE

INJURY NUMBER

__ __ - __ __ __ __ __ __

_____,
Employee

vs.

_____,
Employer

and

_____,
Insurer

_____,
Third Party Administrator

Date of Accident/
Occupational Disease: _____

ENTRY OF APPEARANCE

On behalf of the ☐ Employee ☐ Employer/Insurer ☐ Third Party Administrator

This firm has been retained to represent the indicated client in the above captioned matter. Please enter the name of this firm as attorneys of record for the above, and keep us advised of any and all settings and proceedings which may be held in connection with this case.

Respectfully submitted,

Signature _____
Attorney Name _____
Law Firm _____
Address _____
Phone No. _____
Fax No. _____
Bar No. _____
E-mail Address _____

CERTIFICATE OF SERVICE

I certify that a copy of this Entry of Appearance was mailed or hand delivered to all parties of record, or if represented by an attorney, to their attorneys of record this _____ day of _____, 20____.

Attorney's Signature _____ Bar No. _____

Attorney's Name *(Printed)* _____ Date _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP