



MOTION FOR LEAVE TO WITHDRAW

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_____,)
Employee)
)
 vs.)
)
_____,)
Employer)
)
 and)
)
_____,)
Insurer)
)
_____,)
Third Party Administrator)

**Date of Accident/
Occupational Disease:** _____

MOTION FOR LEAVE TO WITHDRAW

*On behalf of the Employee Employer / Insurer / Third Party Administrator (Please circle the appropriate party.)

COMES NOW, the undersigned attorney and requests Leave to Withdraw as attorney for the _____
(specify the name of the party). In support of the Motion, the undersigned states as follows: _____

Are you requesting a hearing to be set on this Motion: Yes No Is this case set on the docket: Yes No
Is it set for a _____ Pre-hearing _____ Mediation _____ Hearing.
The docket date is _____.

Respectfully submitted,

Signature _____

Are you filing a Lien in this case: Yes No

Attorney Name _____

Law Firm _____

Address _____

Phone No. _____

Fax No. _____

Bar No. _____

Email Address _____

Leave Granted: _____
Administrative Law Judge

Date: _____

CERTIFICATE OF SERVICE

I certify that a copy of this Motion for Leave to Withdraw 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

*The attorney submitting this withdrawal has notified or attempted to notify his/her client of the intent to withdraw pursuant to

Missouri Supreme Court Rule, Rule 4-1.16.

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

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