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

SUBSTITUTION OF COUNSEL

INJURY NUMBER

		-						

_____, **Employee**

vs.

_____, **Employer**

and

_____, **Insurer**

_____, **Third Party Administrator**

Date of Accident/ Occupational Disease: _____

SUBSTITUTION OF COUNSEL

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

COMES NOW, the undersigned attorneys and request substitution of counsel in the above case.

Respectfully Submitted,

Entering Firm/Attorney or Co-Counsel

Signature _____
Attorney Name _____
Law Firm _____
Address _____
City, State, ZIP _____
Phone No. _____
Fax No. _____
Bar No. _____
Email Address _____

Withdrawing Firm/Attorney or Co-Counsel

Signature _____
Attorney Name _____
Law Firm _____
Address _____
City, State, ZIP _____
Phone No. _____
Fax No. _____
Bar No. _____
Email Address _____

Comments/Statements: _____

CERTIFICATE OF SERVICE

I certify that a copy of this Substitution of Counsel 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

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