

EMPLOYEE PETITION FOR REVIEW OF INCAPACITY AND REQUEST FOR PROVISIONAL ORDER

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE)	EMPLOYER
NAME: _____)	NAME: _____
STREET/P.O. BOX: _____)	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____)	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____)	
EMPLOYEE SOCIAL SECURITY NUMBER: _____)	INSURANCE COMPANY
BOARD FILE NUMBER: _____ (IF KNOWN))	NAME: _____
)	STREET/P.O. BOX: _____
		CITY, _____ STATE, _____ ZIP: _____

1. On _____, _____
MONTH DAY YEAR EMPLOYEE NAME
 experienced a work-related injury while working for _____.
EMPLOYER NAME

2. Compensation of \$ _____ per week is being paid for _____ incapacity.
PARTIAL, TOTAL (SELECT ONE)

3. Compensation benefits were _____ as of _____.
REDUCED, DISCONTINUED (SELECT ONE) MONTH, DAY YEAR

4. The employer should reinstate the employee's weekly compensation benefits for the following reasons:
(Attach recent medical reports and/or other documents to support this petition.)

WHEREFORE, the employee asks that the Board issue a provisional order reinstating compensation benefits until a formal decision is ordered pursuant to 39-A M.R.S.A. §205.

SIGNATURE OF EMPLOYEE DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP