PETITION TO DETERMINE AVERAGE WEEKLY WAGE

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

PETITIONER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

RESPONDENT

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

RESPONDENT

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

On _____, _____ , _____
MONTH DAY YEAR EMPLOYEE NAME

experienced a work-related injury while working for _____.
EMPLOYER NAME

WHEREFORE, the petitioner asks the Board to determine the correct average weekly wage pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF PETITIONER

DATED: _____
MONTH DAY YEAR

EMPLOYEE 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 PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525