

PETITION FOR AWARD OF COMPENSATION

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

PETITIONER

RESPONDENT

NAME: _____)

NAME: _____)

STREET/P.O. BOX: _____)

STREET/P. O. BOX: _____)

CITY, STATE, ZIP: _____)

CITY, STATE, ZIP: _____)

TELEPHONE NUMBER: _____)

EMPLOYEE SOCIAL SECURITY NUMBER: _____)

RESPONDENT

BOARD FILE NUMBER: _____)

NAME:

(IF KNOWN)

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. Describe how the injury occurred: _____

3. List body part(s) injured: _____

4. The employee _____ lose time from work.

DID, DID NOT (SELECT ONE)

WHEREFORE, the petitioner asks the Board to order the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

_____ Weekly lost time benefits

_____ Protection of the Act

_____ Specific loss benefits

SIGNATURE OF PETITIONER

DATED: _____

MONTH

DAY

YEAR

EMPLOYEE FILING INSTRUCTIONS

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

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.

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

WCB-140 (06/98)