PETITION FOR AWARD OF COMPENSATION - OCCUPATIONAL DISEASE LAW

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

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME) developed a work-related disease while working for _____ (EMPLOYER NAME).
2. Date of last exposure: _____ (MONTH DAY YEAR).
3. Date of incapacity: _____ (MONTH DAY YEAR).
4. Date employment ceased: _____ (MONTH DAY YEAR).
5. Describe how the exposure occurred:

_____

6. Describe the occupational disease:

_____

7. List the body part(s) affected:

_____

WHEREFORE, the employee asks the Board to award the payment of compensation pursuant to 39-A M.R.S.A.

_____
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

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