

PETITION FOR REINSTATEMENT

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: _____) NAME: _____
BOARD FILE NUMBER: _____) STREET/P.O. BOX: _____
(IF KNOWN)) CITY, STATE, ZIP: _____

INSURANCE COMPANY

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

2. List the body part(s) injured : _____

3. On _____, I contacted the employer and requested the following (check all that apply):
MONTH DAY YEAR
_____ Reinstatement to my former position
_____ Placement in an available position for which I was qualified and physically able to perform

4. On _____, the employer denied this request.
MONTH DAY YEAR

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

- _____ Payment of weekly benefits during the period of denial or until I accept other employment and earn a wage in excess of my average weekly wage.
- _____ Reinstatement to my former position or any other available position for which I am qualified and physically able to perform.
- _____ Other (specify): _____

SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

NAME OF EMPLOYEE'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-171 (06/98)