PETITION TO DETERMINE EXTENT OF PERMANENT IMPAIRMENT

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: _____	RESPONDENT
EMPLOYEE SOCIAL SECURITY NUMBER: _____	NAME: _____
BOARD FILE NUMBER: _____ (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. The injury resulted in a permanent impairment to (list body part(s) affected):

   _____

WHEREFORE, the petitioner asks the Board to determine the extent of permanent impairment.

_____
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 copy for yourself and keep the green certified mail cards when returned to you by the 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