

PETITION TO REMEDY DISCRIMINATION

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: _____)	
BOARD FILE NUMBER: _____ (IF KNOWN))	

1. The above-named employer discriminated against me as a result of a work-related injury on: _____
MONTH DAY YEAR
2. Explain how the employer discriminated:

WHEREFORE, the employee asks the Board to order the following benefits pursuant to 39-A M.R.S.A. §353 (check all that apply):

- Back wages
- Reinstatement to my former position or any other available position for which I am qualified and physically able to perform
- Reestablishment of my employee benefits
- Payment of reasonable attorney fees

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

WCB-195 (06/98)