ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512
workerscomp@alaska.gov

Petition

(Do Not Use As A Claim For Benefits)

AWCB Case Number:

To the Person Receiving this Petition: You have 20 days after the date this petition was served on you to respond in writing or ask for a hearing before the Alaska Workers' Compensation Board (AWCB). Your response to this petition must be filed with the AWCB, and it must show that a copy was given to the person who submitted this petition (see #21 below). If you have an attorney and you have questions, contact your attorney. If you do not have an attorney and you have questions, contact the AWCB.

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
4. Address					5. Social Security No.
City	State	Zip Code	Telephone		6. Date of Birth
7. Employer				8. Insurer	
9. Address				10. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

PETITION TYPE – CHECK APPROPRIATE BOXES.

11. ☐ PROTECTIVE ORDER

12. ☐ COMPEL DISCOVERY

13. ☐ CONTINUE OR CANCEL HEARING

14. ☐ SIME - EXAMINATION BY BOARD-SELECTED PHYSICIAN UNDER AS 23.30.095(k)

15. ☐ REVIEW OF REEMPLOYMENT BENEFIT DECISION UNDER AS 23.30.041

16. ☐ RECONSIDERATION OR MODIFICATION

17. ☐ JOIN ADDITIONAL EMPLOYER(S) AND/OR INSURER(S): Pursuant to 8 AAC 45.040(g), the person or party to be joined as a party will be joined unless within 20 days after the service of this petition the person or party files an objection with the board and serves the objection on all parties in accordance with 8 AAC 45.060.

18. ☐ OTHER: _____

REASON FOR PETITION – STATE IN DETAIL. ATTACH ADDITIONAL PAGES IF NECESSARY.

19. ☐ COMPLETE MEDICAL SUMMARY (Form 07-6103) AND ATTACH IF REQUIRED UNDER 8 AAC 45.052.

20. PROOF OF SERVICE: I certify that on the date in #23 below I served a true and correct copy of this petition on the following (your petition will be returned if you do not show service to all parties and employers/insurers sought to be joined):

a. ☐ The employee in #1 at the address in #4.
b. ☐ The employer in #7 at the address in #9.
c. ☐ The insurer in #8 at the address in #10.
d. ☐ Other (State Name and Address): _____

FORM WILL BE RETURNED UNLESS SIGNED BELOW

21. Name of Individual Filing this Form (Print or Type)	22. Signature	23. Date
24. Address	City State Zip Code	

FILE WITH ALASKA WORKERS' COMPENSATION BOARD