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

AFFIDAVIT OF READINESS FOR HEARING

AWCB Case Number:]
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served, whichever come Attach a completed "I Kttach a "Request for	s first. Do not su Medical Summa · Cross-Examina	ubmit this form unless you ry" (Form 07-6103) if you	y to request a hearing after an a are fully prepared for a hearing have new reports since your la examine the authors of any me hearing held.	g. Before your case wi st Medical Summary, o dical reports listed on	Il be set for a hearing, except as provided in 8 any party's "Medical S	you must comply with the AAC 45.052.	ition Claim or petition was e following instructions:	
Employee's Name (Last, First, Middle Initial)				Date Received (Board Use Only) 3. Date of Injury			ury	
4. Address				5. Social Securit	ty Number	6. Date of Bir	th	
City	State	Zip Code	Telephone	7. Insurer/Adjusting Company				
8. Employer				9. Insurer Addre	ess			
10. Employer Addres	S			City	State	Zip Code	Telephone	
City	State	Zip Code	Telephone	11. Is Employee	now receiving comp	ensation payments?		
•		F		○ Yes ○ N	lo Weekly Comp	ensation Rate \$		
12. Having first been	duly sworn, I s	tate that I have comple	eted necessary discovery, ol			lly prepared for a hear	ing on the issues set forth in	
	-		O Petition(s) Dated	•			•	
13. Please Schedule	(Choose one):	Oral Hearing		Hearing on the Re	cord	Hearing on the	Record with Briefs	
Location:	Anchorage		Fairbank			eau		
\bigcirc	3301 Eagle St Anchorage Ak	treet, Suite 304		Avenue, Station K s, AK 99701-4593). Box 115512, Juneau 1 W 8th St Rm 307, J		
I requested an or	al hearing and		nesses (not including witnes hours.					
14. Attorney Name a			110013.				15. Telephone	
14. / Momey Name an	ia i iiii i vaiiic	(ii represented)					10. Telephone	
16. Attorney Address				City		State	Zip Code	
17. Name of Affiant (I	Print or Type)			18. Signature (Signature (Signature)	gn in Front of Notary	/)		
19. Affiant Address				City	State	Zip Code	Telephone	
NOTA DV DUDUO				20. PROOF OF S	SERVICE (Required	I): I certify that on the	date in #23 below, I mailed	
NOTARY PUBLIC				a true and correct copy of the above affidavit to the following (affidavit will be returned				
Notary Public in and for the State of				with no action if all parties are not served): a. The employee in #1 above at the address in #4.				
				I— :	oyer in #8 above at			
				· ·	er in #7 above at the			
				d. Other (na	me and address bel	ow):		
M. O								
My Commission Expi				-				
Subscribed and swor		day of	·	_				
21. Name of Person S	Serving Affidav	vit		22. Signature			23. Date	
f a narty reasiving this a	ffidavit is not rac	adv for boaring the party	must some on the other parties	and file with the Divis	ion of Markora! Comp	postion at the office ob	acked in how #12 on Affidovit of	

If a party receiving this affidavit is not ready for hearing, the party must serve on the other parties and file with the Division of Workers' Compensation, at the office checked in box #13, an Affidavit of Opposition within 10 days of the "Date Served" shown in box #23. If no Affidavit of Opposition is filed timely, a hearing will be set within 60 days.