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. Your response to this petition must be filed with the Alaska Workers' Compensation Board (AWCB), and it must show that a copy was given to the person who submitted this petition (see #22 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 Birth	4. Date of Injury
5. Address	City	State Zip Code		E-mail Address	Telephone
6. Employer			7. Insurer/Adjusting Company		
8. Address	City	State Zip Code	9. Address	City	State Zip Code
E-mail Address	Telephone	Fax Number	E-mail address	Telephone	Fax Number

PETITION TYPE – CHECK APPROPRIATE BOXES.

10. ☐ PROTECTIVE ORDER
11. ☐ COMPEL DISCOVERY
12. ☐ CONTINUE OR CANCEL HEARING
13. ☐ SIME - EXAMINATION BY BOARD-SELECTED PHYSICIAN UNDER AS 23.30.095(k)
14. ☐ REVIEW OF REEMPLOYMENT BENEFIT ADMINISTRATOR'S DECISION UNDER AS 23.30.041 AND REQUEST FOR HEARING UNDER AS 23.30.110
15. ☐ RECONSIDERATION
16. ☐ JOIN ADDITIONAL EMPLOYER(S) AND/OR INSURER(S): Pursuant to 8 AAC 45.040(g).
17. ☐ MODIFICATION AS 23.30.130
18. ☐ REQUEST FOR EXTENSION OF TIME TO REQUEST A HEARING UNDER AS 23.30.110(c)
19. ☐ OTHER: _____

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

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

21. PROOF OF SERVICE: I certify that on the date in #23 below, I provided 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 to the address/e-mail in #5 by:	☐ Mail	☐ E-mail	
b.	The EMPLOYER in #6 to the address/e-mail/fax in #8 by:	☐ Mail	☐ E-mail	☐ Facsimile
c.	The INSURER in #7 to the address/e-mail/fax #9 by:	☐ Mail	☐ E-mail	☐ Facsimile
d.	OTHER (state name and address, e-mail or fax) by:	☐ Mail	☐ E-mail	☐ Facsimile

FORM WILL BE RETURNED UNLESS SIGNED BELOW

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

FILE WITH ALASKA WORKERS' COMPENSATION BOARD