

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 Birth	4. Date of Injury
5. Address	City State Zip Code	E-mail Address	Telephone Fax Number
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. <input type="checkbox"/> PROTECTIVE ORDER 11. <input type="checkbox"/> COMPEL DISCOVERY 12. <input type="checkbox"/> CONTINUE OR CANCEL HEARING 13. <input type="checkbox"/> SIME - EXAMINATION BY BOARD-SELECTED PHYSICIAN UNDER AS 23.30.095(k) 14. <input type="checkbox"/> REVIEW OF REEMPLOYMENT BENEFIT ADMINISTRATOR'S DECISION UNDER AS 23.30.041 15. <input type="checkbox"/> RECONSIDERATION OR MODIFICATION	16. <input type="checkbox"/> 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. 17. <input type="checkbox"/> REQUEST FOR EXTENSION OF TIME TO REQUEST A HEARING UNDER AS 23.30.110(c) 18. <input type="checkbox"/> OTHER: _____
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REASON FOR PETITION – STATE IN DETAIL. ATTACH ADDITIONAL PAGES IF NECESSARY.

19. <input type="checkbox"/> 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 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/fax in #5 by: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Facsimile
b. The EMPLOYER in #6 to the address/e-mail/fax in #8 by: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Facsimile
c. The INSURER in #7 to the address/e-mail/fax #9 by: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Facsimile
d. OTHER (state name and address, e-mail or fax) by: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Facsimile

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