

ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Appellant, <i>(party filing appeal)</i>	
VS.	
Appellee(s). <i>(all other parties to appeal)</i>	

AWCAC Appeal No. _____
 AWCB Decision No. _____
 AWCB Case No. _____

REQUEST FOR ORAL ARGUMENT BY SELF-REPRESENTED APPEAL PARTICIPANT

I, _____, am the: Appellant Appellee

I request that the Commission schedule oral argument in this appeal. I will attend in person.

by telephone. Please call me at this telephone number when oral argument begins:

(_____) _____

Signature Date

Mailing Address

City, State, Zip

Telephone Number Fax Number and/or Email

The person filing this document MUST sign above.

CERTIFICATE OF SERVICE			
I certify that on _____ (date) this request for oral argument was <input type="checkbox"/> mailed, <input type="checkbox"/> faxed, <input type="checkbox"/> emailed, or <input type="checkbox"/> hand delivered to the Alaska Workers' Compensation Appeals Commission; and I certify that on this same date a copy of this request for oral argument that was filed with the Commission was <input type="checkbox"/> mailed or <input type="checkbox"/> hand delivered to the parties checked at the addresses listed below. <i>(attach additional pages if more addresses must be listed)</i>			
	<input type="checkbox"/> Opposing party OR party's attorney (if represented):		
<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 50%; text-align: center;"> _____ <small><i>Print name of person who mailed / delivered request</i></small> </td> <td style="border: none; width: 50%; text-align: center;"> _____ <small><i>(signature of person who mailed / delivered request)</i></small> </td> </tr> </table>		_____ <small><i>Print name of person who mailed / delivered request</i></small>	_____ <small><i>(signature of person who mailed / delivered request)</i></small>
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NOTE: IF YOU REQUIRE ACCOMMODATION TO PARTICIPATE IN ORAL ARGUMENT, PLEASE CONTACT THE COMMISSION CLERK DIRECTLY BY TELEPHONE AT (907) 269-6738 or E-MAIL AT awcac.clerk@alaska.gov