

# Petition

**(Do Not Use As A Claim For Benefits)**

AWCB Case Number:
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**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. <input type="checkbox"/> PROTECTIVE ORDER	16. <input type="checkbox"/> RECONSIDERATION OR MODIFICATION
12. <input type="checkbox"/> COMPEL DISCOVERY	17. <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.
13. <input type="checkbox"/> CONTINUE OR CANCEL HEARING	18. <input type="checkbox"/> OTHER: _____
14. <input type="checkbox"/> SIME - EXAMINATION BY BOARD-SELECTED PHYSICIAN UNDER AS 23.30.095(k)	
15. <input type="checkbox"/> REVIEW OF REEMPLOYMENT BENEFIT DECISION UNDER AS 23.30.041	

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

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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 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):				
<table style="width: 100%;"> <tr> <td style="width: 50%;">a. <input type="checkbox"/> The employee in #1 at the address in #4.</td> <td style="width: 50%;">b. <input type="checkbox"/> The employer in #7 at the address in #9.</td> </tr> <tr> <td>c. <input type="checkbox"/> The insurer in #8 at the address in #10.</td> <td>d. <input type="checkbox"/> Other (State Name and Address): _____</td> </tr> </table>	a. <input type="checkbox"/> The employee in #1 at the address in #4.	b. <input type="checkbox"/> The employer in #7 at the address in #9.	c. <input type="checkbox"/> The insurer in #8 at the address in #10.	d. <input type="checkbox"/> Other (State Name and Address): _____
a. <input type="checkbox"/> The employee in #1 at the address in #4.	b. <input type="checkbox"/> The employer in #7 at the address in #9.			
c. <input type="checkbox"/> The insurer in #8 at the address in #10.	d. <input type="checkbox"/> 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**