

# EMPLOYEE PETITION FOR REVIEW OF INCAPACITY AND REQUEST FOR PROVISIONAL ORDER

STATE OF MAINE  
WORKERS' COMPENSATION BOARD  
27 STATE HOUSE STATION  
AUGUSTA, MAINE 04333-0027

## EMPLOYEE

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: XXX-XX-\_\_\_\_\_  
(only last four digits required)  
BOARD FILE NUMBER: \_\_\_\_\_

## EMPLOYER

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

## INSURER

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

1. On \_\_\_\_\_, \_\_\_\_\_ sustained a work-related  
injury while working for \_\_\_\_\_.  
MONTH DAY YEAR EMPLOYEE NAME EMPLOYER NAME

2. Compensation of \$ \_\_\_\_\_ per week is being paid for \_\_\_\_\_ incapacity.  
PARTIAL / TOTAL (INSERT ONE)

3. Compensation benefits were \_\_\_\_\_ as of \_\_\_\_\_.  
REDUCED / DISCONTINUED (INSERT ONE) MONTH DAY YEAR

4. The employer should reinstate the employee's weekly compensation benefits for the following reasons:  
**(Attach recent medical reports and/or other documents to support this petition.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THEREFORE, the employee asks that the board issue a provisional order reinstating compensation benefits pursuant to 39-A M.R.S.A. §205.

\_\_\_\_\_  
SIGNATURE OF PETITIONER

DATED: \_\_\_\_\_  
MONTH DAY YEAR

## FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to each other party named in the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

\_\_\_\_\_  
NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)  
\_\_\_\_\_  
STREET/P.O. BOX  
\_\_\_\_\_  
CITY, STATE, ZIP  
\_\_\_\_\_  
TELEPHONE NUMBER