APPLICATION FOR EVALUATION
EMPLOYMENT REHABILITATION SERVICES
PURSUANT TO 39-A M.R.S.A. §217(1)

A party opposing the application shall file an objection no later than 10 business days after receipt of the application per Board Rule Ch. 6, §3 (2). Objections must be filed with the Office of Medical/Rehabilitation Services:

STATE OF MAINE
WORKERS' COMPENSATION BOARD
OFFICE OF MEDICAL/REHABILITATION SERVICES
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
PHONE NUMBER: _____
EMAIL: _____
DATE OF BIRTH: _____
AVERAGE WEEKLY WAGE: _____
BOARD FILE NUMBER: _____
REPRESENTATIVE (IF ANY): _____
REPRESENTATIVE EMAIL: _____

EMPLOYER/CLAIM ADMINISTRATOR

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
CONTACT: _____
EMAIL: _____

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
CONTACT: _____
EMAIL: _____

1. On _____, _____ sustained a work-related
   (MONTH DAY YEAR) (EMPLOYEE NAME)

   injury while working for _____ .
   (EMPLOYER NAME)

2. The employee injured his/her _____.
   (LIST BODY PARTS INJURED)

3. Employment rehabilitation services have not been voluntarily offered and accepted.

4. The employee _____ received benefits previously and _____ receiving benefits currently.
   (HAS / HAS NOT) (IS / IS NOT)

THEREFORE, the applicant asks the board to refer the employee to a board-approved facility for evaluation of the need for and kind of service, treatment, or training necessary and appropriate to return the employee to suitable employment pursuant to 39-A M.R.S.A. §217(1).

_____
SIGNATURE OF APPLICANT

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original application along with a copy of the applicant's relevant medical records to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy with an attachment index to each party **by certified mail, return receipt requested.**
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 APPLICANT

_____
STREET/P.O. BOX

_____
CITY, STATE, ZIP

_____
EMAIL ADDRESS

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.