

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

CONSENT BETWEEN EMPLOYER AND EMPLOYEE

1. REVISION DATE: ____/____/____ MM DD YYYY	2. WCB FILE NUMBER (if known):
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EMPLOYEE				
3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: ()
12. DATE OF INJURY: ____/____/____ MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	

EMPLOYER/INSURER		
15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER NAME:	19. INSURER MAILING ADDRESS AND PHONE NUMBER:	

20. TERMS OF CONSENT:			
20A. DATE OF INCAPACITY:	20B. AVERAGE WEEKLY WAGE:	20C. CURRENT WEEKLY COMPENSATION RATE: TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/>	20D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): YES <input type="checkbox"/> NO <input type="checkbox"/>
20E. NEW COMPENSATION RATE:	20F. EFFECTIVE DATE OF REDUCTION:	20G. EFFECTIVE DATE OF DISCONTINUANCE:	20H. AMOUNT PAID:

NOTICE TO EMPLOYEE (Please read and initial)	
21. BEFORE YOU SIGN THIS FORM, YOU SHALL CALL THE WORKERS' COMPENSATION BOARD'S OFFICES TO FIND OUT WHAT RIGHTS YOU HAVE IF YOU SIGN THIS FORM. A LIST OF THE BOARD'S REGIONAL OFFICES IS SHOWN AT THE BOTTOM OF THIS PAGE.	
EMPLOYEE INITIALS: _____	

NOTICE TO EMPLOYER	
THIS FORM SHALL NOT BE USED FOR CASES WHEN AN ORDER, AWARD OF COMPENSATION OR A COMPENSATION SCHEME WAS ENTERED UNDER SECTION 205 (9)(B)(2).	

CONSENT	
22. WE AGREE TO THE TERMS LISTED IN BOX 20 ABOVE. WE UNDERSTAND THAT THIS IS NOT A FINAL SETTLEMENT. SIGNING THIS CONSENT FORM CREATES A PAYMENT WITHOUT PREJUDICE, DOES NOT CREATE A PAYMENT SCHEME, AND DOES NOT PREVENT EITHER PARTY FROM REOPENING THE CLAIM WITHIN CERTAIN TIME LIMITS. THIS FORM MUST BE SIGNED BY THE EMPLOYEE, EMPLOYEE'S ATTORNEY OR WORKER ADVOCATE IF ANY, AND THE EMPLOYER/INSURER OR BY A DULY AUTHORIZED REPRESENTATIVE.	
_____ EMPLOYEE SIGNATURE	_____ DATE
_____ EMPLOYEE'S AUTHORIZED REPRESENTATIVE SIGNATURE (IF APPLICABLE)	_____ DATE
_____ EMPLOYER/INSURER OR AUTHORIZED REPRESENTATIVE SIGNATURE	_____ DATE

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES				
AUGUSTA 442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	BANGOR 396 GRIFFIN RD, STE105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	CARIBOU ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	LEWISTON 36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	PORTLAND 56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:
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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: 1-888-801-9087 or TTY Maine Relay 711.
WCB-4A (eff. 9/1/20, rev. 3/11/2026)