

# DISCONTINUANCE OF COMPENSATION

1. REVISION DATE:  MM / DD / YYYY		<b>STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027</b>				2. WCB FILE NUMBER (if known):	
<b>EMPLOYEE</b>							
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:		
<b>EMPLOYER/INSURER</b>							
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. REASON FOR DISCONTINUANCE:

<input type="checkbox"/> RETURNED TO WORK FOR SAME EMPLOYER REGULAR/FULL DUTY MEDICAL RELEASE	<input type="checkbox"/> RETURNED TO WORK FOR SAME EMPLOYER EARNING AT/ABOVE AVERAGE WEEKLY WAGE
<input type="checkbox"/> BOARD DECISION	<input type="checkbox"/> NOC FILED WITHIN 45 DAYS PURSUANT TO §205(2)(2)(C)
<input type="checkbox"/> OTHER (EXPLAIN) _____	

21. PERIOD OF INCAPACITY: FROM (DATE):  TO (RETURN DATE):	22. WEEKLY COMPENSATION RATE:	23. AMOUNT PAID:	24. DATE FINAL PAYMENT MAILED:
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25. COMMENTS:

**ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES**

<b>AUGUSTA</b> 442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	<b>BANGOR</b> 106 HOGAN RD BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	<b>CARIBOU</b> ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	<b>LEWISTON</b> 36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	<b>PORTLAND</b> 1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858
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26. PREPARER NAME (REQUIRED):  E-MAIL ADDRESS (REQUIRED):	27. TELEPHONE NUMBER (REQUIRED):  TOLL-FREE NUMBER:	28. DATE MAILED:  MM / DD / YYYY
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