PETITION FOR REINSTATEMENT

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: _____

NOTICE

A party is not required to file a written response to this petition under 39-A M.R.S.A. §307(3). Upon notice of a claim for incapacity or death benefits, however, the employer/insurer must comply with the provisions of 90 MAR 351 Ch.1. §1 or the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S.A. §205(2) and in compliance with 39-A M.R.S.A. §204.

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME) sustained a work-related injury while working for _____ (EMPLOYER NAME).

2. The injury occurred _____ (DESCRIBE HOW THE INJURY HAPPENED) and the employee injured their _____ (LIST BODY PARTS INJURED).

3. On _____ (MONTH DAY YEAR), the employee contacted the employer and requested the following (check all that apply):
   - ☐ Reinstatement to their former position.
   - ☐ Placement in an available position for which they were qualified and physically able to perform.
   - ☐ Other (specify): _____

4. On _____ (MONTH DAY YEAR), the employer denied this request.

5. The employer has _____ (UNDER/OVER (INSERT ONE)) 200 employees, to the best of the employee's knowledge.

THEREFORE, the employee asks the board to order benefits pursuant to Title 39-A.

_____
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

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.

WCB-171 (effective 1/1/13, revised 10/11/23)