PETITION TO REMEDY DISCRIMINATION

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: _____

WORKERS' COMPENSATION INSURER (NOTICE ONLY)

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

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

2. The above-named employer discriminated against the employee for testifying or asserting a claim under Title 39-A in the following ways (explain how the employer discriminated):

_____
_____
_____
_____

THEREFORE, the employee asks the board to order relief pursuant to 39-A M.R.S.A. §353.

_____
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-195 (eff. 1/1/13)