APPENDIX A:
CALCULATION OF BENEFITS[1]

INJURIES ON OR AFTER 1-1-2013

The following methods of calculating incapacity benefits are acceptable for the purpose of Board audits:

Total Incapacity (Section 212)

Payments for a fraction of a week shall be figured in sevenths (1/7). This calculation includes Saturday and Sunday.

Example: Assume Hearing Officer orders employee to be paid for 16 days.

Weekly Compensation Rate x 2 2/7
= Weekly Compensation Rate x 16/7 = Amount Due

Partial Incapacity (Section 213)

The weekly compensation is equal to 2/3 of the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the average gross weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 211.

To calculate partial benefits:

(1) Determine the weekly compensation rate for the employee's pre-injury average weekly wage. Pre-injury average weekly wage x 2 ÷ 3.

(2) Determine the weekly compensation rate for the employee's post-injury gross weekly wages. Post-injury gross weekly wages x 2 ÷ 3.

(3) Subtract the post-injury rate from the pre-injury rate. The difference is the partial benefit amount due for the week.

Example: Assume January 2013 date of injury, pre-injury average weekly wage of $400 and employee returns to work part-time, earning $200 per week.

Wage	Rate
$400	$266.66
$200	$133.33
	$133.33 Partial Benefit Amount Due

[1] If fringe benefits are involved, they will be included pursuant to Section 102(4)(H).

APPENDIX B:
AWW CALCULATION

Average weekly wages must be calculated in accordance with Section 102(4), of the Maine Workers' Compensation Act of 1992. Furthermore, the applicability of subsections A, B, C and D must be considered in the order that those subsections appear.

The following pages provide examples of typical WCB-2, Wage Statements. Each example contains an "AWW calculation explanation" at the bottom of the page. These "AWW calculation explanations" are designed to offer general guidance for the application of Section 102(4). They are for illustrative purposes only, and do not represent official Board policy.

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Store	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Bess	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 5/10/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	5/22/10	400.00	19	9/25/10	350.00	37	1/29/11	225.00
2	5/29/10	425.00	20	10/2/10	250.00	38	2/5/11	225.00
3	6/5/10	425.00	21	10/9/10	325.00	39	2/12/11	350.00
4	6/12/10	425.00	22	10/16/10	200.00	40	2/19/11	275.00
5	6/19/10	450.00	23	10/23/10	250.00	41	2/26/11	275.00
6	6/26/10	425.00	24	10/30/10	300.00	42	3/5/11	250.00
7	7/3/10	500.00	25	11/6/10	250.00	43	3/12/11	225.00
8	7/10/10	475.00	26	11/13/10	300.00	44	3/19/11	325.00
9	7/17/10	450.00	27	11/20/10	325.00	45	3/26/11	350.00
10	7/24/10	450.00	28	11/27/10	500.00	46	4/2/11	400.00
11	7/31/10	450.00	29	12/4/10	450.00	47	4/9/11	400.00
12	8/7/10	490.00	30	12/11/10	425.00	48	4/16/11	350.00
13	8/14/10	Includes advance vacation pay 800.00	31	12/18/10	455.00	49	4/23/11	325.00
14	8/21/10	0.00	32	12/25/10	650.00	50	4/30/11	375.00
15	8/28/10	425.00	33	1/1/11	400.00	51	5/7/11	350.00
16	9/4/10	425.00	34	1/8/11	300.00	52	5/14/11	400.00
17	9/11/10	350.00	35	1/15/11	250.00	21. TOTAL EARNINGS	$	**19,020.00**
18	9/18/10	325.00	36	1/22/11	250.00	22. GROSS AVERAGE WEEKLY WAGE	$	**365.77**

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. Vacation pay for the week ending 8/21/10 appears to have been paid during the week ending 8/14/10 (see documentation above). Therefore, the Total Earnings should be divided by 52 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Self-employed logger	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Chuck	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 5/11/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	1/8/10	800.00	19	5/14/10	1350.00	37	9/17/10	1225.00
2	1/15/10	825.00	20	5/21/10	950.00	38	9/24/10	1225.00
3	1/22/10	725.00	21	5/28/10	1325.00	39	10/1/10	1350.00
4	1/29/10	925.00	22	6/4/10	1200.00	40	10/8/10	725.00
5	2/5/10	950.00	23	6/11/10	1250.00	41	10/15/10	275.00
6	2/12/10	925.00	24	6/18/10	1300.00	42	10/22/10	1450.00
7	2/19/10	1500.00	25	6/25/10	1250.00	43	10/29/10	1450.00
8	2/26/10	1475.00	26	7/2/10	1300.00	44	11/5/10	1450.00
9	3/5/10	0.00	27	7/9/10	1325.00	45	11/12/10	890.00
10	3/12/10	0.00	28	7/16/10	500.00	46	11/19/10	800.00
11	3/19/10	0.00	29	7/23/10	550.00	47	11/26/10	780.00
12	3/26/10	0.00	30	7/30/10	825.00	48	12/3/10	1425.00
13	4/2/10	0.00	31	8/6/10	755.00	49	12/10/10	1425.00
14	4/9/10	0.00	32	8/13/10	650.00	50	12/17/10	1350.00
15	4/16/10	.00	33	8/20/10	400.00	51	12/24/10	650.00
16	4/23/10	0.00	34	8/27/10	700.00	52	12/31/10	700.00
17	4/30/10	0.00	35	9/3/10	1250.00	**21. TOTAL EARNINGS**	$ **43,750.00**	
18	5/7/10	325.00	36	9/10/10	1250.00	**22. GROSS AVERAGE WEEKLY WAGE**	$ **841.35**	

AWW calculation explanation: Logging is seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be divided by 52 weeks.

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Store	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Bob	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 5/12/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	5/22/10	200.00	19	9/25/10	150.00	37	1/29/11	325.00
2	5/29/10	225.00	20	10/2/10	200.00	38	2/5/11	400.00
3	6/5/10	400.00	21	10/9/10	425.00	39	2/15/11	225.00
4	6/12/10	325.00	22	10/16/10	375.00	40	2/19/11	250.00
5	6/19/10	275.00	23	10/23/10	175.00	41	2/26/11	330.00
6	6/26/10	280.00	24	10/30/10	125.00	42	3/5/11	320.00
7	7/3/10	400.00	25	11/6/10	155.00	43	3/12/11	275.00
8	7/10/10	475.00	26	11/13/10	145.00	44	3/19/11	250.00
9	7/17/10	425.00	27	11/20/10	275.00	45	3/26/11	200.00
10	7/24/10	425.00	28	11/27/10	225.00	46	4/2/11	200.00
11	7/31/10	340.00	29	12/4/10	250.00	47	4/9/11	450.00
12	8/7/10	350.00	30	12/11/10	275.00	48	4/16/11	400.00
13	8/14/10	230.00	31	12/18/10	300.00	49	4/23/11	325.00
14	8/21/10	320.00	32	12/25/10	350.00	50	4/30/11	350.00
15	8/28/10	425.00	33	1/1/11	160.00	51	5/7/11	180.00
16	9/4/10	400.00	34	1/8/11	140.00	52	5/14/11	220.00
17	9/11/10	350.00	35	1/15/11	130.00	21. TOTAL EARNINGS	$	**14,895.00**
18	9/18/10	375.00	36	1/22/11	120.00	22. GROSS AVERAGE WEEKLY WAGE	$	**287.75**

AWW calculation explanation: This employee's biweekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 5/14/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder ($14,675.00) should then be divided by 51 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Store	8. EMPLOYEE LAST NAME:	9. FIRST NAME: David	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 6/15/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49	5/28/11	50.00
14			32			50	6/4/11	400.00
15			33			51	6/11/11	200.00
16			34			52	6/18/11	150.00
17			35			**21. TOTAL EARNINGS**	$ **800.00**	
18			36			**22. GROSS AVERAGE WEEKLY WAGE**	$ **Unknown**	

AWW calculation explanation: There are not enough weeks to apply §102(4)(A), and §102(4)(C) cannot be used because this is not seasonal employment. Section 102(4)(B) may not be reasonable or fair in this case, therefore, comparable employees' wages should be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at an AWW that reasonably represents the employee's weekly earning capacity (§102(4)(D)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Factory	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Bruce	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 7/25/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	8/7/10	420.00	19	12/11/10	468.00	37	4/16/11	650.00
2	8/14/10	400.00	20	12/18/10	492.00	38	4/23/11	650.00
3	8/21/10	352.00	21	12/25/10	500.00	39	4/30/11	425.00
4	8/28/10	468.00	22	1/1/11	488.00	40	5/7/11	455.00
5	9/4/10	500.00	23	1/8/11	500.00	41	5/14/11	465.00
6	9/11/10	325.00	24	1/15/11	472.00	42	5/21/11	410.00
7	9/18/10	250.00	25	1/22/11	468.00	43	5/28/11	465.00
8	9/25/10	600.00	26	1/29/11	300.00	44	6/4/11	400.00
9	10/2/10	425.00	27	2/5/11	350.00	45	6/11/11	500.00
10	10/9/10	390.00	28	2/12/11	375.00	46	6/18/11	352.00
11	10/16/10	350.00	29	2/19/11	590.00	47	6/25/11	468.00
12	10/23/10	425.00	30	2/26/11	425.00	48	7/2/11	500.00
13	10/30/10	400.00	31	3/5/11	400.00	49	7/9/11	325.00
14	11/06/10	600.00	32	3/12/11	350.00	50	7/16/11	250.00
15	11/13/10	525.00	33	3/19/11	400.00	51	7/23/11	425.00
16	11/20/10	500.00	34	3/26/11	425.00	52	7/30/11	100.00
17	11/27/10	550.00	35	4/2/11	325.00	21. TOTAL EARNINGS	$	**22,848.00**
18	12/4/10	600.00	36	4/9/11	600.00	22. GROSS AVERAGE WEEKLY WAGE	$	**446.04**

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 7/30/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder ($22,748.00) should then be divided by 51 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Office	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Barbara	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 7/26/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1			19			37	4/16/11	450.00
2			20	12/18/10	250.00	38	4/23/11	450.00
3			21	12/25/10	450.00	39	4/30/11	450.00
4			22	1/1/11	450.00	40	5/7/11	450.00
5			23	1/8/11	450.00	41	5/14/11	450.00
6			24	1/15/11	450.00	42	5/21/11	450.00
7			25	1/22/11	450.00	43	5/28/11	450.00
8			26	1/29/11	450.00	44	6/4/11	450.00
9			27	2/5/11	450.00	45	6/11/11	450.00
10			28	2/12/11	450.00	46	6/18/11	450.00
11			29	2/19/11	450.00	47	6/25/11	450.00
12			30	2/26/11	450.00	48	7/2/11	450.00
13			31	3/5/11	450.00	49	7/9/11	450.00
14			32	3/12/11	450.00	50	7/16/11	450.00
15			33	3/19/11	450.00	51	7/23/11	450.00
16			34	3/26/11	450.00	52	7/30/11	300.00
17			35	4/2/11	450.00	**21. TOTAL EARNINGS**		$ **14,500.00**
18			36	4/9/11	450.00	**22. GROSS AVERAGE WEEKLY WAGE**		$ **450.00**

AWW calculation explanation: It appears that this employee did not work at least 200 full workdays during the preceding year, so §102(4)(A) cannot be used. The week ending 12/18/10 includes the week of hire, and the week ending 7/30/11 includes the date of injury. Both of the aforementioned weeks reduce the AWW, and should therefore be excluded. The remainder ($13,950.00) should then be divided by 31 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Factory	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Brenda	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 7/28/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	8/7/10	420.00	19	12/11/10	468.00	37	4/16/11	650.00
2	8/14/10	400.00	20	12/18/10	492.00	38	4/23/11	650.00
3	8/21/10	0.00	21	12/25/10	500.00	39	4/30/11	425.00
4	8/28/10	468.00	22	1/1/11	0.00	40	5/7/11	455.00
5	9/4/10	500.00	23	1/8/11	500.00	41	5/14/11	465.00
6	9/11/10	325.00	24	1/15/11	472.00	42	5/21/11	410.00
7	9/18/10	250.00	25	1/22/11	468.00	43	5/28/11	465.00
8	9/25/10	600.00	26	1/29/11	300.00	44	6/4/11	400.00
9	10/2/10	425.00	27	2/5/11	350.00	45	6/11/11	500.00
10	10/9/10	390.00	28	2/12/11	375.00	46	6/18/11	352.00
11	10/16/10	350.00	29	2/19/11	0.00	47	6/25/11	468.00
12	10/23/10	425.00	30	2/26/11	425.00	48	7/2/11	500.00
13	10/30/10	400.00	31	3/5/11	400.00	49	7/9/11	325.00
14	11/06/10	600.00	32	3/12/11	350.00	50	7/16/11	0.00
15	11/13/10	525.00	33	3/19/11	400.00	51	7/23/11	425.00
16	11/20/10	500.00	34	3/26/11	425.00	52	7/30/11	600.00
17	11/27/10	550.00	35	4/2/11	325.00	**21. TOTAL EARNINGS**		**$ 21,668.00**
18	12/4/10	600.00	36	4/9/11	600.00	**22. GROSS AVERAGE WEEKLY WAGE**		**$ 451.42**

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. There were no earnings during the weeks ending 8/21/10, 1/1/11, 2/19/11 and 7/16/11, so those weeks should be excluded, and the Total Earnings should be divided by 48 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Summer Camp	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Carl	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 8/16/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43	6/18/11	400.00
8			26			44	6/25/11	400.00
9			27			45	7/2/11	400.00
10			28			46	7/9/11	400.00
11			29			47	7/16/11	400.00
12			30			48	7/23/11	400.00
13			31			49	7/30/11	400.00
14			32			50	8/6/11	400.00
15			33			51	8/13/11	400.00
16			34			52	8/20/11	400.00
17			35			**21. TOTAL EARNINGS**	$ **4,000.00**	
18			36			**22. GROSS AVERAGE WEEKLY WAGE**	$ **Unknown**	

AWW calculation explanation: Summer camps are seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be obtained and then be divided by 52 weeks. (The wages listed above are for the current calendar year.)

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: School	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Barney	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 9/26/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	10/9/10	750.00	19	2/12/11	750.00	37	6/18/11	750.00
2	10/16/10	750.00	20	2/19/11	750.00	38	6/25/11	0.00
3	10/23/10	750.00	21	2/26/11	750.00	39	7/2/11	0.00
4	10/30/10	750.00	22	3/5/11	750.00	40	7/9/11	0.00
5	11/6/10	750.00	23	3/12/11	750.00	41	7/16/11	0.00
6	11/13/10	750.00	24	3/19/11	750.00	42	7/23/11	0.00
7	11/20/10	750.00	25	3/26/11	750.00	43	7/30/11	0.00
8	11/27/10	750.00	26	4/2/11	750.00	44	8/6/11	0.00
9	12/4/10	750.00	27	4/9/11	750.00	45	8/13/11	0.00
10	12/11/10	750.00	28	4/16/11	750.00	46	8/20/11	0.00
11	12/18/10	750.00	29	4/23/11	750.00	47	8/27/11	0.00
12	12/25/10	750.00	30	4/30/11	750.00	48	9/3/11	800.00
13	1/1/11	750.00	31	5/7/11	750.00	49	9/10/11	800.00
14	1/8/11	750.00	32	5/14/11	750.00	50	9/17/11	800.00
15	1/15/11	750.00	33	5/21/11	750.00	51	9/24/11	800.00
16	1/22/11	750.00	34	5/28/11	750.00	52	10/1/11	800.00
17	1/29/11	750.00	35	6/4/11	750.00	21. TOTAL EARNINGS	$	**31,750.00**
18	2/5/11	750.00	36	6/11/11	750.00	22. GROSS AVERAGE WEEKLY WAGE	$	**755.95**

AWW calculation explanation: Most teachers and other school personnel do not work at least 200 full workdays during a calendar year. Therefore, §102(4)(A) cannot be used in those situations. Based on the actual circumstances of the employment, §102(4)(B) might produce a fair and reasonable AWW (Total Earnings divided by 42 weeks = $755.95.) If it does not, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW (§102(4)(D)). [§102(4)(C) cannot be used because schools are not seasonal employers.]

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Office	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Alice	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 10/7/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	10/16/10	600.00	19	2/19/11	600.00	37	6/25/11	650.00
2	10/23/10	600.00	20	2/26/11	600.00	38	7/2/11	650.00
3	10/30/10	600.00	21	3/5/11	600.00	39	7/9/11	650.00
4	11/6/10	600.00	22	3/12/11	600.00	40	7/16/11	650.00
5	11/13/10	600.00	23	3/19/11	600.00	41	7/23/11	650.00
6	11/20/10	600.00	24	3/26/11	600.00	42	7/30/11	650.00
7	11/27/10	600.00	25	4/2/11	650.00	43	8/6/11	650.00
8	12/4/10	600.00	26	4/9/11	650.00	44	8/13/11	650.00
9	12/11/10	600.00	27	4/16/11	650.00	45	8/20/11	650.00
10	12/18/10	600.00	28	4/23/11	650.00	46	8/27/11	650.00
11	12/25/10	800.00	29	4/30/11	650.00	47	9/3/11	650.00
12	1/1/11	600.00	30	5/7/11	650.00	48	9/10/11	650.00
13	1/8/11	600.00	31	5/14/11	650.00	49	9/17/11	650.00
14	1/15/11	600.00	32	5/21/11	650.00	50	9/24/11	650.00
15	1/22/11	600.00	33	5/28/11	650.00	51	10/1/11	650.00
16	1/29/11	600.00	34	6/4/11	650.00	52	10/8/11	650.00
17	2/5/11	600.00	35	6/11/11	650.00	**21. TOTAL EARNINGS**	$ **32,800.00**	
18	2/12/11	600.00	36	6/18/11	650.00	**22. GROSS AVERAGE WEEKLY WAGE**	$ **650.00**	

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was $650.00.

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Sales	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Brian	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 11/3/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK		GROSS EARNINGS	WK			WK		
1	11/13/10	500.00	19	3/19/11	900.00	37	7/23/11	730.00
2	11/20/10	600.00	20	3/26/11	775.00	38	7/30/11	1500.00
3	11/27/10	400.00	21	4/2/11	700.00	39	8/6/11	1000.00
4	12/4/10	700.00	22	4/9/11	950.00	40	8/13/11	600.00
5	12/11/10	875.00	23	4/16/11	900.00	41	8/20/11	600.00
6	12/18/10	825.00	24	4/23/11	675.00	42	8/27/11	725.00
7	12/25/10	775.00	25	4/30/11	725.00	43	9/3/11	775.00
8	1/1/11	800.00	26	5/7/11	700.00	44	9/10/11	800.00
9	1/8/11	700.00	27	5/14/11	800.00	45	9/17/11	775.00
10	1/15/11	825.00	28	5/21/11	900.00	46	9/24/11	950.00
11	1/22/11	750.00	29	5/28/11	850.00	47	10/1/11	850.00
12	1/29/11	900.00	30	6/4/11	900.00	48	10/8/11	600.00
13	2/5/11	950.00	31	6/11/11	1000.00	49	10/15/11	710.00
14	2/12/11	875.00	32	6/18/11	800.00	50	10/22/11	895.00
15	2/19/11	950.00	33	6/25/11	925.00	51	10/29/11	1000.00
16	2/26/11	700.00	34	7/2/11	850.00	52	11/5/11	600.00
17	3/5/11	800.00	35	7/9/11	750.00	**21. TOTAL EARNINGS**	$	**41,705.00**
18	3/12/11	800.00	36	7/16/11	770.00	**22. GROSS AVERAGE WEEKLY WAGE**	$	**805.98**

AWW calculation explanation: This employee's semi-monthly earnings generally varied, so §102(4)(A) cannot be used. The week ending 11/5/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder ($41,105.00) should then be divided by 51 weeks (§102(4)(B)).

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Office	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Adam	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: / 14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 11/9/11	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	11/20/10	550.00	19	3/26/11	550.00	37	7/30/11	600.00
2	11/27/10	550.00	20	4/2/11	550.00	38	8/6/11	600.00
3	12/4/10	550.00	21	4/9/11	550.00	39	8/13/11	600.00
4	12/11/10	550.00	22	4/16/11	550.00	40	8/20/11	600.00
5	12/18/10	550.00	23	4/23/11	550.00	41	8/27/11	600.00
6	12/25/10	550.00	24	4/30/11	550.00	42	9/3/11	575.00
7	1/1/11	650.00	25	5/7/11	550.00	43	9/10/11	600.00
8	1/8/11	550.00	26	5/14/11	600.00	44	9/17/11	600.00
9	1/15/11	550.00	27	5/21/11	600.00	45	9/24/11	600.00
10	1/22/11	550.00	28	5/28/11	600.00	46	10/1/11	600.00
11	1/29/11	550.00	29	6/4/11	600.00	47	10/8/11	600.00
12	2/5/11	550.00	30	6/11/11	600.00	48	10/15/11	600.00
13	2/12/11	550.00	31	6/18/11	600.00	49	10/22/11	600.00
14	2/19/11	550.00	32	6/25/11	800.00	50	10/29/11	650.00
15	2/26/11	550.00	33	7/2/11	600.00	51	11/5/11	650.00
16	3/5/11	550.00	34	7/9/11	600.00	52	11/12/11	130.00
17	3/12/11	550.00	35	7/16/11	600.00	**21. TOTAL EARNINGS**	$ **29,855.00**	
18	3/19/11	550.00	36	7/23/11	600.00	**22. GROSS AVERAGE WEEKLY WAGE**	$ **650.00**	

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was $650.00.

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME: Temp Agency	8. EMPLOYEE LAST NAME:	9. FIRST NAME: Bill		10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY: 11/10/11	17. DESCRIPTION OF INJURY:		

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1	11/20/10	600.00	19	3/26/11	0.00	37	7/30/11	0.00
2	11/27/10	600.00	20	4/2/11	0.00	38	8/6/11	500.00
3	12/4/10	500.00	21	4/9/11	0.00	39	8/13/11	900.00
4	12/11/10	600.00	22	4/16/11	200.00	40	8/20/11	900.00
5	12/18/10	500.00	23	4/23/11	400.00	41	8/27/11	850.00
6	12/25/10	550.00	24	4/30/11	600.00	42	9/3/11	825.00
7	1/1/11	625.00	25	5/7/11	600.00	43	9/10/11	850.00
8	1/8/11	0.00	26	5/14/11	600.00	44	9/17/11	800.00
9	1/15/11	0.00	27	5/21/11	600.00	45	9/24/11	750.00
10	1/22/11	0.00	28	5/28/11	600.00	46	10/1/11	900.00
11	1/29/11	0.00	29	6/4/11	200.00	47	10/8/11	450.00
12	2/5/11	300.00	30	6/11/11	0.00	48	10/15/11	500.00
13	2/12/11	800.00	31	6/18/11	0.00	49	10/22/11	0.00
14	2/19/11	800.00	32	6/25/11	0.00	50	10/29/11	0.00
15	2/26/11	750.00	33	7/2/11	0.00	51	11/5/11	200.00
16	3/5/11	750.00	34	7/9/11	0.00	52	11/12/11	450.00
17	3/12/11	800.00	35	7/16/11	0.00	21. TOTAL EARNINGS	$	**21,350.00**
18	3/19/11	500.00	36	7/23/11	0.00	22. GROSS AVERAGE WEEKLY WAGE	$	**614.71**

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. ***There were no earnings during the weeks ending 1/8/11, 1/15/11, 1/22/11, 1/29/11, 3/26/11, 4/2/11, 4/9/11, 6/11/11, 6/18/11, 6/25/11, 7/2/11, 7/9/11, 7/16/11, 7/23/11, 7/30/11, 10/22/11 and 10/29/11, so those weeks must be excluded. The week ending 11/12/11 includes the date of injury and reduces the AWW, so it too should be excluded, and the remainder ($20,900.00) should be divided by 34 weeks (§102(4)(B)). [If, based on the actual circumstances of the employment, §102(4)(B) does not produce a fair and reasonable AWW, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW (§102(4)(D)). §102(4)(C) cannot be used because temp agencies are not seasonal employers.]***

APPENDIX C:
ADDITIONAL NOC INFORMATION

Full Denial Reason Codes (DN198)		
1	**No Compensable Accident**	
	A	Coming and Going
	B	Horseplay
	C	Willful Intent to Injure Oneself
	D	Does Not Meet Statutory Definition of Accident
	E	Deviation From Employment
	F	Recreational/Social Activity
	G	Traveling Employee
	H	Subsequent Intervening Accident
2	**No Causal Relationship**	
	A	Idiopathic Condition
	B	Pre-existing Condition
	C	Stress Non-Work Related
	D	No Medical Evidence of Injury
	E	No Injury Per Statutory Definition
	F	Accident Not Major Contributing Cause of Injury
3	**No Coverage**	
	A	No Employer/Employee Relationship
	B	Independent Contractor
	C	Does Not Meet Statutory Definition of Employee
	D	No Jurisdiction
	E	No Policy in Effect on the Date of Accident
	F	Statute of Limitation Expired
	G	Statutory Exemptions (Sole Proprietor, Corporate Officer, etc.)
	H	Elected Other Coverage (24 hour, Collective Bargaining, Opted Out)
4	**Substance Abuse**	
	A	Injury Primarily Occasioned by Intoxication or Use of Any Drug
5	**Other (Not Elsewhere Classified)**	
	A	Failure to Report Accident Timely
	C	Misrepresentation

Partial Denial Reason Codes (DN294)	
A	Denying Indemnity in Whole, not Medical
B	Denying Indemnity in Part, not Medical
C	Denying Medical in Whole, Not Indemnity
D	Denying Medical in Part, Not Indemnity
E	Denying Indemnity in Whole, Medical in Part
F	Denying Medical in Whole, Indemnity in Part
G	Denying Both Indemnity & Medical in Part

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE # (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID:
DN43 & DN255	DN44	DN45	TYPE: DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE #:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER/CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE #:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER/CLAIM ADMIN NAME AND ADDRESS:	18. INSURER/CLAIM ADMIN FEIN:
DN188, NA – DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

DN198

19b. **PARTIAL DENIAL REASON**

DN294

20a. DATE OF INITIAL INCAPACITY ___/DN56/___
CURRENT DATE OF INCAPACITY ___/DN144/___

20b. DATE EMPLOYER NOTIFIED ____/DN281_/____

FULL DENIAL EFFECTIVE DATE ___/DN199_/____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

21. COMMENTS:

DN197

22. If the employer fails to comply with the provisions of Rule 1.1, 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. § 205(2) and in compliance with 39-A M.R.S. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met: A. The employer files a Notice of Controversy; and B. The employer pays benefits from the date the claim is made. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____/DN100_/____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only): ____/____/____

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-9 (eff. 1/1/13)

FULL DENIAL OF A MEDICAL ONLY CLAIM

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE# (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID:
DN43	DN44	DN45	TYPE: DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE#:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER CLAIM ADMIN NAME AND ADDRESS:	18. INSURER CLAIM ADMIN FEIN:
DN188, NA– DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

DN198

Values (Enter no more than five):

1 (A,B,C,D,E,F,G or H)

2 (A,B,C,D,E or F)

3 (A,B,C,D,E,F,G,or H)

4 (A)

5 (A or C)

FULL DENIAL EFFECTIVE DATE ____/DN199 /____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

19b. **PARTIAL DENIAL REASON**

20a.

DATE OF INITIAL INCAPACITY ___/__/___

CURRENT DATE OF INCAPACITY ___/__/___

20b.

DATE EMPLOYER NOTIFIED ____/__/_____

21. **COMMENTS:**

DN197(Enter narrative)

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST SUITE 2	106 HOGAN ROAD	43 HATCH DRIVE SUITE 110	36 MOLLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04336-5220	04401-5638	04736-2347	04240-5811	04101-3061
(207) 287-2308 (Voice)	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854 (Voice)	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858
TTY 1-877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____/DN100 _/____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only) ____/____/____

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone 888-801-9087 or TTY (877) 832-5525.

DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

FULL DENIAL OF A LOST TIME CLAIM

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE # (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID :
DN43	DN44	DN45	TYPE : DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE #:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER /CLAIM ADMI N FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE #:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER/ CLAIM ADMIN NAME AND ADDRESS:	18. INSURER/ CLAIM ADMIN FEIN :
DN188, NA – DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW.
IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

DN198
Values (Enter no more than five):

1 (A,B,C,D,E,F,G or H)

2 (A,B,C,D,E or F)

3 (A,B,C,D,E,F,G,or H)

4 (A)

5 (A or C)

FULL DENIAL EFFECTIVE DATE ___ /DN199 /____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

19b. **PARTIAL DENIAL REASON**

20a.

DATE OF INITIAL INCAPACITY ___/ DN56/___
CURRENT DATE OF INCAPACITY ___/ __/__

20b.

DATE EMPLOYER NOTIFIED ____/ DN281 /____

21. **COMMENTS:**

DN197 (Enter narrative)

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1 ,** the employee must be pai d total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39 -A M.R.S.A. § 205(2) and in compliance with 39 -A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits. Payment under Rule 1.1 r equires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEW ISTON	PORTLAND
24 STONE ST. SUITE 2	106 HOGAN ROAD	43 HATCH DRIVE SUITE 110	36 MOLLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04330 -5220	04401 -5638	04736 -2347	04240 -5811	04101 -3061
(207)287 -2308 (Voice)	(207)941 -4550	(207)498 -6428	(207)7 53-7700	(207)822 -0840
1-800-400-6854 (Voice)	1-800-400-6856	1 -800-400-6855	1 -800-400-6857	1 -800-400-6858
TTY 1 -877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SEN T TO WCB:
DN140	( ) DN137	____/ DN100 /____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only) : ____/____/____

WCB -9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, o r activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: 1 -888-801-9087 or TTY (877) 832 -5525.
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOY ER

PARTIAL DENIAL OF INITIAL INCAPACITY

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE# (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID
DN43	DN44	DN45	TYPE: DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE#:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 / /	NA-DN35	NA – DN36

EMPLOYER

14. INSURER/CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE#:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER/CLAIM ADMIN NAME AND ADDRESS:	18. INSURER/CLAIM ADMIN FEIN:
DN188, NA– DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

19b. **PARTIAL DENIAL REASON**

DN294
Values = A,B,E,F or G

20a.

DATE OF INITIAL INCAPACITY ___DN56/___
CURRENT DATE OF INCAPACITY ___/___/___

FULL DENIAL EFFECTIVE DATE /___/___

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

20b.

DATE EMPLOYER NOTIFIED ____DN281_/_____

21. **COMMENTS:**

DN197(Enter narrative)

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39 M.R.S.A. § 205(2) and in compliance with 39 M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of accrued benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST SUITE 2	106 HOGAN ROAD	43 HATCH DRIVE SUITE 110	36 MOLLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04336-5220	04401-5638	04736-2347	04246-5811	04101-3061
(207)287-2308 (Voice)	(207)941-4550	(207)496-6428	(207)753-7700	(207)822-0840
1-800-400-6854 (Voice)	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858
TTY 1-877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____DN100_/_____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only) _____/_____/_____

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone 800-801-9087 or TTY (877) 832-5525.
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

PARTIAL DENIAL OF A MEDICAL ONLY CLAIM

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE# (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID
DN43	DN44	DN45	TYPE DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE#:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER/CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER/CLAIM ADMIN NAME AND ADDRESS:	18. INSURER/CLAIM ADMIN FEIN:
DN188, NA – DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

19b. **PARTIAL DENIAL REASON**

DN294
Values = C or D

20a. DATE OF INITIAL INCAPACITY ___/ /___
CURRENT DATE OF INCAPACITY ___/___/___

FULL DENIAL EFFECTIVE DATE ___/___/_____

20b. DATE EMPLOYER NOTIFIED ___/___/_____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

21. **COMMENTS:**

DN197 (Enter narrative)

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1**, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39 M.R.S.A. § 205(2) and in compliance with 39 M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any due benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST SUITE 2	106 HOGAN ROAD	43 HATCH DR SUITE 110	36 MILLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04336-9220	04401-5638	04736-2347	04240-5811	04101-3061
(207)287-2308 (Voice)	(207)941-4550	(207)496-6428	(207)753-7700	(207)822-0840
1-800-400-6854 (Voice)	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858
TTY 1-877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____DN100_/____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only) ____/____/____

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone 888-801-9087 or TTY (877) 832-5525.
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

PARTIAL DENIAL OF SUBSEQUENT INCAPACITY

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE # (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID:
DN43	DN44	DN45	TYPE: DN270 #: DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE #:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE #:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER CLAIM ADMIN NAME AND ADDRESS:	18. INSURER CLAIM ADMIN FEIN:
DN188, NA– DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

FULL DENIAL EFFECTIVE DATE __/__/____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

19b. **PARTIAL DENIAL REASON**

DN294
Values = A,B,E ,F or G

20a.

DATE OF INITIAL INCAPACITY ___/DN56/___
CURRENT DATE OF INCAPACITY ___/DN144/___

20b.

DATE EMPLOYER NOTIFIED ____/DN281 _/____

21. **COMMENTS:**

DN197 (Enter narrative)

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1,1** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST SUITE 2	106 HOGAN ROAD	43 HATCH DRIVE SUITE 110	36 MOLLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04336-5220	04401-5638	04736-2347	04240-5811	04101-3061
(207) 287-2308 (Voice)	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854 (Voice)	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858
TTY 1-877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____/DN100 _/____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only) ____/____/____

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone 1-800-801-9087 or TTY (877) 832-5525.
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

APPENDIX D:
FROI CROSSWALK

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE NUMBER (if known): **DN5**

1a. OSHA 300 CASE NUMBER (if applicable): NA

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS **DN74** 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO NA

3. ☐ LOST EARNINGS BUT NO LOST TIME NA 4. ☐ MEDICAL/HEALTH CARE **DN74** 5. ☐ FATALITY DATE OF DEATH: ____/____/____ **DN57**
Also see DN146 MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE **DN290** 6b. DATE OF LAST EXPOSURE: ____/____/____ **DN31** 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ NA
MM DD YYYY MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT **DN2** 7b. DATE OF CORRECTION: ____/____/____ **DN3** 7c. DATE CORRECTION SENT TO WCB: ____/____/____ **DN3**
Note: also see correction process & DN295, 296 MM DD YYYY MM DD YYYY

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): **DN329**	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): **DN16**		10. EMPLOYER NAME: **DN18**	
11. STREET/P.O BOX MAILING ADDRESS: **DN168-169**	12. CITY: **DN165**	13. STATE: **DN170**	14. ZIP: **DN167**	15. TELEPHONE NUMBER: **DN159** ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: **DN25**	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: **DN19-23** EMPLOYER PHYSICAL COUNTRY CODE = **DN164**		18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO **DN249** IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: **DN120; 119, 122, 121, 123, 33, 118** ACCIDENT SITE COUNTRY CODE = **DN280**	

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME: **DN7/188**	20. POLICY NUMBER: **DN28**		21. INSURER FILE NUMBER: **DN15**	
22. STREET/P.O. BOX MAILING ADDRESS: **DN10-11**	23. CITY: **DN12**	24. STATE: **DN13**	25. ZIP: **DN14**	26. TELEPHONE NUMBER: ( ) NA

27. LAST NAME: **DN43 & DN255**	28. FIRST NAME: **DN44**	29. MI: **DN45**	30. TELEPHONE NUMBER: ( ) **DN51**	31. SOCIAL SECURITY NUMBER: **DN42**	32. GENDER: **DN53** ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS: **DN46-47**	34. CITY: **DN48**		35. STATE: **DN49**	36. ZIP: **DN50**	37. DATE OF BIRTH: **DN52** ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE: **DN60**	39. DATE OF HIRE: **DN61** ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $ **DN62**		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS: NA	

42. DATE OF INJURY OR ILLNESS: ____/____/____ **DN31** MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ **DN40** MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ **DN56** MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ **DN281** MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): NA 46. TIME OF INJURY (e.g. 1:10 p.m.): **DN32**	45. DATE EMPLOYER NOTIFIED INSURER/TPA OF INJURY: ____/____/____ **DN41** MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO **DN189** IF YES, GIVE DATE: ____/____/____ **DN68** MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): **DN35**	49. BODY PART(s) AFFECTED (e.g. lower right forearm): **DN36**	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): **DN37**

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): NA	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): **DN38**

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO NA	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO: NA	55. HEALTH CARE PROVICER NAME: NA	56. MAILING ADDRESS: NA	57. TELEPHONE NUMBER: ( ) NA

58. PREPARER NAME AND TITLE (TYPE OR PRINT): NA	59. TELEPHONE NUMBER: ( ) NA	60. DATE SENT TO WCB: **DN100** ____/____/____ MM DD YYYY

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-1 (eff. 1/1/13)