ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

AFFIDAVIT OF READINESS FOR HEARING

AWCB Case Number:

Before you complete and submit this form, read carefully. Use only to request a hearing after an answer has been filed or at least 20 days after a Workers' Compensation Claim or petition was served, whichever comes first. Do not submit this form unless you are fully prepared for a hearing. Before your case will be set for a hearing, you must comply with the following instructions:
I. Attach a completed "Medical Summary" (Form 07-6103) if you have new reports since your last Medical Summary, except as provided in 8 AAC 45.052.
II. Attach a "Request for Cross-Examination" if you wish to cross-examine the authors of any medical reports listed on any party's "Medical Summary" to date.
III. Mail this affidavit to the address of the city where you want the hearing held.

1. Employee's Name (Last, First, Middle Initial)	2. Date Received (Board Use Only)	3. Date of Injury
4. Address	5. Social Security Number	6. Date of Birth
City State Zip Code Telephone	7. Insurer/Adjusting Company	
8. Employer	9. Insurer Address	
10. Employer Address	City State Zip Code Telephone	
City State Zip Code Telephone	11. Is Employee now receiving compensation payments? ◯ Yes ◯ No Weekly Compensation Rate $ _____	

12. Having first been duly sworn, I state that I have completed necessary discovery, obtained necessary evidence, and am fully prepared for a hearing on the issues set forth in the ◯ Workers' Compensation Claims(s) OR ◯ Petition(s) Dated _____

13. Please Schedule (Choose one): ◯ Oral Hearing ◯ Hearing on the Record ◯ Hearing on the Record with Briefs

Location:
◯ Anchorage, 3301 Eagle Street, Suite 304, Anchorage AK 99503
◯ Fairbanks, 675 7th Avenue, Station K, Fairbanks, AK 99701-4593
◯ Juneau, P.O. Box 115512, Juneau AK 99811-5512, 1111 W 8th St Rm 307, Juneau AK 99801

I requested an oral hearing and expect _____ witnesses (not including witnesses who will testify by deposition), including _____ medical witnesses, and estimate the time required for my portion of the hearing will be _____ hours.

14. Attorney Name and Firm Name (If represented)			15. Telephone
16. Attorney Address	City	State	Zip Code
17. Name of Affiant (Print or Type)	18. Signature (Sign in Front of Notary)		
19. Affiant Address	City State Zip Code Telephone		

NOTARY PUBLIC _____

Notary Public in and for the State of _____

My Commission Expires: _____

Subscribed and sworn to me this _____ day of _____, _____

20. **PROOF OF SERVICE (Required):** I certify that on the date in #23 below, I mailed a true and correct copy of the above affidavit to the following (affidavit will be returned with no action if all parties are not served):

- ☐ a. The employee in #1 above at the address in #4.
- ☐ b. The employer in #8 above at the address in #10.
- ☐ c. The insurer in #7 above at the address in #9
- ☐ d. Other (name and address below):

21. Name of Person Serving Affidavit	22. Signature	23. Date

If a party receiving this affidavit is not ready for hearing, the party must serve on the other parties and file with the Division of Workers' Compensation, at the office checked in box #13, an Affidavit of Opposition within 10 days of the "Date Served" shown in box #23. If no Affidavit of Opposition is filed timely, a hearing will be set within 60 days.