

ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Appellant, <i>(party filing appeal)</i>	
VS.	
Appellee(s). <i>(all other parties to appeal)</i>	AWCAC Appeal No. _____ AWCB Decision No. _____ AWCB Case No. _____

SELF-REPRESENTED APPELLANT'S AMENDED NOTICE OF APPEAL

Please take notice that I, _____, appeal Decision No. _____, issued on _____, by the Alaska Workers' Compensation Board in AWCB Case No. _____. A copy of the Board decision that I am appealing is attached to this notice.

AMENDED STATEMENT OF GROUNDS FOR APPEAL

The grounds (reasons) for this appeal are: _____

 _____ (Attach more pages if needed.)

The person filing this document MUST sign below.

Signature	Date
Mailing Address	
City, State, Zip	
Telephone Number	Fax Number and/or E-mail

CERTIFICATE OF SERVICE		
I certify that on _____ (date) this Amended Notice of Appeal and Amended Statement of Grounds were <input type="checkbox"/> mailed, <input type="checkbox"/> faxed, <input type="checkbox"/> emailed, or <input type="checkbox"/> hand delivered to the Alaska Workers' Compensation Appeals Commission, and on the same date a complete copy of this document was <input type="checkbox"/> mailed, <input type="checkbox"/> faxed, <input type="checkbox"/> emailed, or <input type="checkbox"/> hand delivered to the parties checked at the addresses listed below. (Attach more pages if needed.)		
<input checked="" type="checkbox"/> Required: Director, Alaska Workers' Compensation Division P.O. Box 115512 Juneau, AK 99811	<input type="checkbox"/> If opposing party is a State agency: Attorney General's Office P.O. Box 110300 Juneau, AK 99811-0300	<input type="checkbox"/> Opposing party or party's attorney (if represented): _____ _____
_____ <i>Print name of person who served document</i>		_____ <i>Signature of person who served document</i>