ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 25512
Juneau, Alaska 99802-5512

Request for Cross-Examination

AWCB Case Number

Instructions: This form is to be filed to request cross-examination of the author of any report listed on a "Medical Summary" or any nonmedical document. To be used when you file an "Affidavit of Readiness for Hearing," an "Affidavit of Opposition," or a "Medical Summary" or within 10 days after another party files a "Medical Summary."

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim No.	3. Date of Injury
4. Address					5. Social Security Number
City	State	Zip Code	Telephone		6. Date of Birth
7. Employer				8. Insurer/Adjusting Company	
9. Address				10. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

I REQUEST THE OPPORTUNITY TO CROSS-EXAMINE THE FOLLOWING WITNESSES FOR THE REASONS STATED:

11. Date of Medical Summary Prepared By	12. Medical Report Date Report Author	13. Reason Cross-Examination is Requested (Be Specific)
a.		
b.		
c.		
d.		
e.		
14. Nonmedical Document Date Document Description	15. Document Author	16. Reason Cross-Examination is Requested (Be Specific)
a.		
b.		

17. Name of Person Submitting Request (Print or Type)	18. Signature
19. Address	City State Zip Code Telephone

20. PROOF OF SERVICE: I certify that on the date in #23 below I mailed/delivered a true and correct copy of this request to the following (request 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 #7 above at the address in #9.
c. ☐ The insurer in #8 above at the address in #10.
d. ☐ Other (state name and address):

NAME	ADDRESS
NAME	ADDRESS

21. Name of Person Serving Request	22. Signature	23. Date Served

Form 07-6174 (1/94)