



WORKSAFEBC AUTHORIZATION OF REPRESENTATIVE

You are not required to have a representative for workers' compensation matters. However, if you want someone to act as your representative, complete and sign this form. This form also authorizes WorkSafeBC, including the Review Division, and the Workers' Compensation Appeal Tribunal ("WCAT") to give confidential information about you or your business to your representative.

1. Information about you

WorkSafeBC claim number (if applicable)

(Inform WorkSafeBC or WCAT if your contact details change.)

Last name <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>		First name		Middle initial	
Title and business name (if applicable)					
Mailing address			City		Province
Area code and daytime phone number		Other phone number (include area code)		Fax number (include area code)	
I am <input type="checkbox"/> a worker <input type="checkbox"/> a deceased worker's dependant <input type="checkbox"/> other (explain) _____ <input type="checkbox"/> an employer Classification unit number _____ Account number _____					

2. I want to appoint a representative (You may appoint one person or an organization to represent you.)

<input type="checkbox"/> one person – Name of person <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>		Relationship	
My representative is:		<input type="checkbox"/> an organization – Name of organization	
Representative's mailing address		City	
Area code and daytime phone number		Other phone number (include area code)	
Area code and daytime phone number		Fax number (include area code)	
Contact person <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>			
Representative's mailing address		City	
Area code and daytime phone number		Other phone number (include area code)	
Area code and daytime phone number		Fax number (include area code)	
I consent to WorkSafeBC or WCAT disclosing to my representative the contents of any WorkSafeBC file(s) or related information for which I am eligible to receive disclosure. I authorize my representative to act on my behalf before WorkSafeBC, including the Review Division, or WCAT with respect to those files. This authorization form will replace any previous authorization(s) I have submitted to WCAT or WorkSafeBC for the same scope of representation identified in section 3 of this form. If I cancel this authorization, I understand that I must notify WCAT and the WorkSafeBC department(s) handling my outstanding matters. For individuals: This authorization shall remain in effect for two years from the date of signing, unless I cancel it in writing, or until my death, whichever is earliest. For employers: This authorization shall remain in effect for two years from the date of signing, or until it is cancelled in writing, or the business is no longer active with the WorkSafeBC, whichever is earliest.			

3. Scope of representation

This authorization refers to ALL my claims <input type="checkbox"/>		A single claim for claim number as noted above <input type="checkbox"/>	
My representative will represent me with respect to the following workers' compensation matters, including any reviews or appeals that may arise: (check all that apply)			
All compensation claims matters, including section 10(8) transfers	<input type="checkbox"/>	All relief of costs matters	<input type="checkbox"/>
All return-to-work matters	<input type="checkbox"/>	All discriminatory action matters	<input type="checkbox"/>
All assessment matters, including the authority to settle such matters	<input type="checkbox"/>	All occupational health and safety matters	<input type="checkbox"/>
All certificate matters (e.g. first aid, blasting)	<input type="checkbox"/>	Section 257 certificate matters	<input type="checkbox"/>
or Only the following matters (provide claim number or other details) <input type="checkbox"/>			
Signature (You, not your representative, must sign here.)			Date (yyyy-mm-dd)
X			

Personal information on this form is collected under section 26 of the *Freedom of Information and Protection of Privacy Act* for the purpose of the administration of the *Workers Compensation Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.

