

AUTHORIZATION BY EMPLOYER

Employer's Name _____

Workers' Compensation Board Account Number _____

Address _____

(Postal Code) (Telephone Number) (FAX Number)

This authorizes the following to be our representative respecting Workers' Compensation Board ("WCB") matters, including any reviews before the Review Division of:

- Occupational Health and Safety matters
- Assessment matters
- Compensation and Rehabilitation matters

(Mark as applicable)

For the purposes of reviews, we consent to the WCB disclosing to our representative the contents of our WCB file(s) or any other WCB file(s) or related information to which we are eligible to receive disclosure, in the categories marked above. We authorize our representative to act on our behalf in providing evidence and submissions during reviews of any of these matter(s).

We also acknowledge the WCB may obtain or view, from any source whatsoever, a copy of records pertaining to the matter(s) under review.

(Print Name/Title of Representative)

(Representative's Organization Name/ Full Address)

(Postal Code) (Telephone Number) (FAX Number)

Print Name of Person Signing Authorization for Employer _____

Title _____

Signature _____ Date _____

This authorization shall remain in effect for two (2) years, or until it is revoked in writing, or our business has been sold (assets or shares), merged with another employer, becomes inactive, ceases to operate or is otherwise no longer active with the WCB, whichever is earlier.