

AUTHORIZED REPRESENTATIVE CONSENT FORM

WHSCC CLAIM NO./FIRM NO.

(Office Use Only) WHSCRD CASE NO.

1. YOUR CONTACT INFORMATION

NAME	COMPANY NAME (If Applicable)			
ADDRESS				
CITY/TOWN	PROV.	POSTAL CODE	TEL.	FAX.

2. AUTHORIZATION AND CONSENT (To be signed by worker/employer/dependant)

Please select the appropriate box:

I _____ (worker or dependant) consent to the following individual to act as my Authorized Representative for the purposes of the WHSCRD review process.

I _____ (on behalf of the Employer) _____ (Employer Name) consent to the following individual to act as the Authorized Representative for the purposes of the WHSCRD review process.

REPRESENTATIVE CONTACT INFORMATION

NAME	AGENCY (If applicable)			
ADDRESS				
CITY/TOWN	PROV.	POSTAL CODE	TEL.	FAX.

I understand the Authorized Representative, as indicated above, will receive information concerning the WHSCRD review and act as the Authorized Representative until indicated otherwise.

Signature	Date
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3. CHANGE OF AUTHORIZED REPRESENTATIVE

Please note that _____ is no longer my Authorized Representative.

I wish to designate _____ as my Authorized Representative. **(Please fill in Section 2 above)**

Signature	Date
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Personal information on this form is collected for the WHSCRD processing of a Request for Review application under the Workplace Health, Safety and Compensation Act and the Access to Information and the Protection of Privacy Act.

For further information, please contact WHSCRD at the address or telephone numbers listed above.