

**EMPLOYER'S NOTICE OF INTENTION TO PARTICIPATE**  
**(TO BE COMPLETED BY THE EMPLOYER)**

If you wish to participate in the review proceedings, you must notify the Workplace Health, Safety and Compensation Review Division's (WHSCRD) office of your intention to do so within 14 days of receipt of this form. If you have any questions or concerns, please contact the WHSCRD office at the address or telephone numbers listed above.

**1. Information concerning the Request for Review**

WHSCRD Case No.	WHSCC Claim/Firm No.	Worker's Name <i>(if applicable)</i>
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**2. Employer's Contact Information** (please print)

<i>Mr. Mrs. Ms.</i>		Employer's Company/Firm Name:		
Mailing address		City	Province	Postal Code
Area code and daytime phone ( )	Other phone ( )	Fax Number ( )		

**3. Will you be participating in the review proceedings?**

If you participate, the WHSCRD will send you a copy of the documents relative to the issue(s) under review. You will also be notified of the review process. Please indicate your preference:

**Yes**, the employer will participate in the review proceedings on this matter.  
*(Name & Address)* \_\_\_\_\_  
will act as the Authorized Representative for the employer on this matter.

**No**, the employer does not wish to participate. The employer understands that it is giving up their right to take part in the review process and no further notice will be given to the employer.

**No**, the employer does not wish to participate, please send a copy of the final decision.

**4. Undertaking of Confidentiality and Signature**

**I agree:**

- the documents or records disclosed on this matter will be used solely for the purpose of the WHSCRD review,
- the documents or records will be kept confidential and secure,
- the Authorized Representative will use documents or records disclosed on this matter solely for the purpose of the WHSCRD review and keep them confidential and secure,
- to return documents or records disclosed, upon the employer's participation in the review process ending, and
- to comply with any other conditions or restrictions the WHSCRD may impose regarding the use and disclosure of documents or records.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Must be signed by an official of the employer – not the Authorized Representative)*

**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.**