



## REQUEST FOR REVIEW APPLICATION

**APPEALED BY (Please check one)**

Worker \_\_\_\_\_ Employer \_\_\_\_\_ Dependant \_\_\_\_\_

**(Office use only)**

W.H.S.C.R.D. Case No: \_\_\_\_\_

**1. W.H.S.C.C. DECISION INFORMATION (Please attach copy)**

DECISION(S) MADE BY:	Date of WHSCC Internal Review decision(s) to be reviewed:
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**2. WORKER INFORMATION**

NAME	CLAIM NUMBER(S) - (This section must be completed)			
ADDRESS				
CITY/TOWN	PROV.	POSTAL CODE	TEL.	FAX.

**3. ACCIDENT EMPLOYER INFORMATION**

CONTACT NAME	COMPANY NAME	FIRM NO.
ADDRESS		
CITY/TOWN	PROV.	POSTAL CODE
	TEL.	FAX.

**4. REPRESENTATIVE INFORMATION (If applicable – an Authorized Representative Consent form must be completed and returned)**

NAME	AGENCY			
ADDRESS				
CITY/TOWN	PROV.	POSTAL CODE	TEL.	FAX.

**5. WHY DO YOU DISAGREE WITH THIS DECISION? (Provide details in full – you may attach additional explanations to this form)**


**6. WHAT TYPE OF BENEFIT ARE YOU REQUESTING? (Please be specific)**


**I confirm the information on this form is correct and complete:**

Signature \_\_\_\_\_

Date \_\_\_\_\_

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.