Workers' Compensation
Independent Review Board
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Website: www.gov.nl.ca/wcirb

AUTHORIZED REPRESENTATIVE CONSENT FORM

WorkplaceNL CLAIM NO./FIRM NO.	**(Office Use Only) WCIRB CASE NO.**

1. YOUR CONTACT INFORMATION:

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

2. AUTHORIZATION AND CONSENT: (To be signed by the worker/employer/dependent)

Please select the appropriate box:

☐ I _____ (Worker/Dependent) consent to the following individual to act as my Authorized Representative for the purposes of the WCIRB review process:

☐ I _____ (on behalf of the Employer) of _____ (Employer Name) consent to the following individual to act as the Employer's Authorized Representative for the purposes of the WCIRB review process:

REPRESENTATIVE CONTACT INFORMATION:

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

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

(To be signed by worker/employer/dependent) **Signature**	**Date**

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)

(To be signed by worker/employer/dependent) **Signature**	**Date**

Personal information on this form is collected for the processing of a WCIRB Request for Review application and subsequent hearing under the Workplace Health, Safety and Compensation Act, 2022 and the Access to Information and the Protection of Privacy Act, 2015. For further information, please contact WCIRB at the address or telephone number listed above.