Workers' Compensation
Independent Review Board
2nd Floor, Dorset Building
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Mount Pearl, NL A1N 3K4

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Fax: (709)729-6956
Toll Free: 1-888-336-1111
Email: wcirb@gov.nl.ca
Website: www.gov.nl.ca/wcirb

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 Workers' Compensation Independent Review Board (WCIRB) 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 WCIRB office at the address or telephone numbers listed above.

1. Information concerning the Request for Review

WCIRB Case No.	WCIRB Claim/Firm No.	Worker's Name *(if applicable)*

2. Employer's Contact Information (please print)

Contact Name(s):		Employer's Company/Firm Name:	
Mailing address	City	Province	Postal Code

Area code and daytime phone ( )	Email	Fax Number ( )

3. Will you be participating in the review proceedings?

If you participate, the WCIRB 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. **(Please submit an Authorized Representative Form)**

❑ **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:

a. the documents or records disclosed on this matter will be used solely for the purpose of the WCIRB review,
b. the documents or records will be kept confidential and secure,
c. the Authorized Representative will use documents or records disclosed on this matter solely for the purpose of the WCIRB review and keep them confidential and secure, and
d. to comply with any other conditions or restrictions the WCIRB 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 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, 2025. For further information, please contact WCIRB at the address or telephone number listed above.

Revised Form February 2025