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

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Toll Free: 1-888-336-1111
Email: wcirb@gov.nl.ca
Website: www.gov.nl.ca/wcirb

WCIRB REQUEST FOR REVIEW APPLICATION

All Sections Must Be Completed

I am the: (Please check one)	**(Office use only)**
Worker: ☐ Employer: ☐ Dependent: ☐	WCIRB Case No:

1. WorkplaceNL DECISION INFORMATION (Please attach copy)

Decision(s) Made By:	Date of WorkplaceNL Internal Review decision(s) to be reviewed:

2. WORKER INFORMATION

Name		Claim Number(s)			
Address		Email			
City/Town	Prov.	Postal Code	Tel.	Cell	

3. ACCIDENT EMPLOYER INFORMATION

Contact Name	Company Name		Firm No.		
Address		Email			
City/Town	Prov.	Postal Code	Tel.	Cell	Fax

4. AUTHORIZATION AND CONSENT: (To be signed by the applicant)

The following individual has consent to act as the 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.	Cell

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.

5. WHY DO YOU DISAGREE WITH THIS DECISION? (Please explain how WorkplaceNL made an error in applying policy and/or legislation)

6. WHAT TYPE OF BENEFIT ARE YOU REQUESTING? (Please note - this should be specific to the decision under review. Benefits not referenced in the internal review decision are not able to be reviewed under this application.)

7. EXTENSION OF TIME REQUEST: (To be completed ONLY if 30 days have passed since your decision date)

As I have exceeded the 30 days provided to file a Request for Review pursuant to S. 39(2) of the **Workplace Health, Safety & Compensation Act** (the **Act**), I hereby apply to the Chief Review Commissioner for an Extension of Time in accordance with S.39(2) of the **Act** to file a Request for Review.

THIS EXTENSION OF TIME IS REQUIRED FOR THE FOLLOWING REASON(S) (Please provide full details):

8. Check your preferred method(s) of hearing (You may check up to two options)

☐ In-person (if available)
☐ Video Conference
☐ Paper Review (attendance not required)
☐ Telephone Conference

9. Form Checklist

Did you attach a copy of the full internal review decision(s) you wish to appeal? ☐

Did you fill out ALL sections? Contact us if you need help completing this application. Send this form as soon as it is completed. ☐

10. I CONFIRM THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE:

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** and the **Access to Information and the Protection of Privacy Act, 2015**. I acknowledge that WCIRB may obtain, view and/or disclose information related to this review to other participating parties for the express purposes of this review. Further, I authorize the representative identified above to act on my behalf for the purposes of this review until otherwise indicated, including providing evidence and making submissions. I understand that it is a serious offence to knowingly provide false information in order to induce particular decisions. Form revised February 2025.