**Workplace Health, Safety and Compensation Review Division**
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# AUTHORIZED REPRESENTATIVE CONSENT FORM

| **WorkplaceNL Claim No./Firm No.** | **Office Use Only**<br><br>**WHSCRD Case No.** |
|---|---|

## 1. YOUR CONTACT INFORMATION:

| Name | Company Name (if applicable) | | | |
|---|---|---|---|---|
| Address | | | | |
| 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 _____ consent to the following individual to act as my Authorized Representative
(Worker/Dependent Name)
for the purposes of the WHSCRD review process:

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

**REPRESENTATIVE CONTACT INFORMATION:**

| Name | Agency (if applicable) | | | |
|---|---|---|---|---|
| Address | | | | |
| City/Town | Prov. | Postal Code | Tel. | Fax. |

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

| To be signed by worker/employer/dependent<br><br>**Signature** | **Date** |
|---|---|

## 3. CHANGE OF AUTHORIZED REPRESENTATIVE:

Please note that _____ is no longer my Authorized Representative.
(Name)
I wish to designate _____ as my Authorized Representative.
(Name)
**(Please fill in Section 2 above)**

| To be signed by worker/employer/dependent<br><br>**Signature** | **Date** |
|---|---|

**Personal information on this form is collected for the processing of a WHSCRD 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*. For further information, please contact WHSCRD at the address or telephone number listed above.**

***Revised Form February 2017***