

**Workplace Health, Safety and
Compensation Review Division**
2nd Floor, Dorset Building
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AUTHORIZED REPRESENTATIVE CONSENT FORM

WorkplaceNL Claim No./Firm No.

Office Use Only
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

Signature	Date
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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

Signature	Date
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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.