

Request for Review

Claim Number: (for requests on claim decisions)
Employer Number: (for requests on account decisions)

Contact Information (Advise the Review Committee in writing if this information changes.)

I am the: <input type="checkbox"/> Worker <input type="checkbox"/> Employer <input type="checkbox"/> Other			My title/position is:	
Last Name:		First Name:		Employer Name
Mailing Address:		City:	Province/Territory:	Postal Code:
Home # (include area code):	Work # (include area code):	Fax # (include area code):	E-mail Address:	

Review Request (Attach additional sheets if necessary.)

I disagree with the WSCC decision letter dated: _____

Issue(s) I disagree with:

Reason(s) I disagree with the decision:

Type of Review Requested (Review Committee does not reimburse travel costs or time missed from work.)

<input type="checkbox"/> Documentary Review	<input type="checkbox"/> Oral Hearing – Select Type	<input type="radio"/> In-person	<input type="radio"/> Telephone	<input type="radio"/> Video Conference
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Representation (If you have a representative, provide the following information.)

Representative/Agency Name:	Phone Number (include area code):	Address:
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I, _____, authorize the Workers' Safety & Compensation Commission of the Northwest Territories and Nunavut to release any pertinent information related to my claim or employer account, and review to _____

The WSCC may use this information for the administration of the Workers' Compensation Acts, the Safety Acts, and/or the Mine Health and Safety Acts, and their associated Regulations.

I understand when the appellant is a worker, the employer may participate, and receive copies of all documents used, in the review.

Applicant's Signature _____ **Date**

MM	DD	YYYY

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Toll Free Fax: 1-866-277-3677 • Email: ReviewCommittee@wsc.nt.ca

or

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