



IMPORTANT: To participate in a review, you must return this completed form to the Review Division by the due date set out below.

Return to: Mailing address: Review Division
WorkSafeBC
PO Box 2071 Stn Terminal
Vancouver BC V6B 3S3
Phone 604 214-5411
Toll-free in B.C. 1 888 922-8804
Fax 604 232-7747
www.WorkSafeBC.com

Worker last name	First name	Middle initial	WorkSafeBC claim number
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Your contact information¹

I am the: Worker <input type="checkbox"/> Employer <input type="checkbox"/> – My title/position is:				Other <input type="checkbox"/> (please describe)	
Last name		First name		Employer name	
Mailing address					
City			Province		Postal code
Work telephone number (please include area code)		Home number (please include area code)		Fax number (please include area code)	

Request for review information

I wish to participate in the review of the (please choose one):		
Compensation decision <input type="checkbox"/>	Assessment decision <input type="checkbox"/>	Prevention decision/order <input type="checkbox"/>
Date(s) of the decision(s) being reviewed (yyyy-mm-dd)		
WorkSafeBC claim or employer number(s)		
Applicant's name		
Review number		

Due date

You must return the form to the Review Division on or before (yyyy-mm-dd):
If we have not received a response by the due date, the review process will proceed without your participation.

New information

Have you attached any new information that was not considered when the decision was originally made?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Will you be sending in new information that was not considered when the decision was originally made?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

¹ If your contact or representation information changes, contact the Review Division with your new information.





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Disclosure for review (copy of WorkSafeBC file)

You will receive a paper copy of WorkSafeBC's file upon receipt of your "Notice to Participate" form. For some Compensation files, disclosure is available in CD format. Please check (✓) the box if you prefer CD format. CD format

Note: If you have a representative, please check the box if you wish disclosure sent to the representative's mailing address. Yes, please send to representative
Otherwise, it will be sent to your mailing address.

Representation¹

Please check (✓) one. I will represent myself in the review process I have a representative who will handle this review

If you are represented:

Representative's name

Representative's organization name

Representative's mailing address

City	Province	Postal code
Telephone number (please include area code)		Fax number (please include area code)

"I wish to participate in this review. I acknowledge that WorkSafeBC may disclose information regarding this file for purposes of review, or may disclose such information to others in accordance with the law, including the *Freedom of Information and Protection of Privacy Act*. Further, and where applicable, I authorize the representative identified above to act on my behalf for the purposes of this review."

Participant name (please print)	Participant signature	Date signed (yyyy-mm-dd)
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