



Workers' Compensation Appeal Tribunal (WCAT)  
#201 – 419 Range Road, Whitehorse, Yukon Y1A 3V1  
Telephone: (867) 667-8731 Fax: (867) 393-7030  
E-mail: [tribunal@yukonwcat.ca](mailto:tribunal@yukonwcat.ca) website: [www.yukonwcat.ca](http://www.yukonwcat.ca)

## Notice of Appeal

### 1. Application Information

Name _____ (Last Name or company name) (First name or contact name if employer)
Address _____ (Apartment No.) (Street)
_____ (City) _____ (Province or Territory) _____ (Postal Code)
Phone No. (home) ( ) _____ E-mail _____ (work) ( ) _____ Fax No. ( ) _____

### 2. Information about decision being appealed (Please check appropriate box)

<input type="checkbox"/> <b>I am the worker.</b> When I was injured I was employed by _____ Type of injury _____
<input type="checkbox"/> <b>I am the worker's dependent.</b> The worker's name is _____ At the time of the injury, the worker was employed by _____
<input type="checkbox"/> <b>I am the employer.</b> The worker's name is _____ Type of injury _____

<b>Claim No(s).</b> _____
Date of decision(s) being appealed _____ <b>Attach a copy of the decision(s) being appealed</b>
Would you prefer: (check one)
<input type="checkbox"/> An oral hearing in front of an appeal committee of the Tribunal.
<input type="checkbox"/> A documentary review hearing based on the documents in your file. Your presence is not required.

**3. Representation** (Please check appropriate box)

- I will be representing myself in this appeal.
- I have a representative. Complete the following information.  
Name of Representative \_\_\_\_\_  
Company, Association or Organization Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. (    ) \_\_\_\_\_ Fax No. (    ) \_\_\_\_\_

**Note: Legal fees and expenses are the responsibility of the appellant and will not be paid by WCB or the Tribunal.**

**4. Reasons for appeal**

**It is important to be as specific as possible.**

I disagree with the decision because:

---

---

---

---

---

Attach additional pages if necessary.

**5. Changes being sought**

Please state the solution or remedy you are looking for on each decision identified.

**Be specific. Provide as much detail as possible.**  
*(For example: Disability benefits from June 30, 2004 to April 6, 2005)*

---

---

---

---

---

---

---

---

**Note: Pursuant to the Tribunal's Rules of Procedure, failure to specifically set out the changes being sought will result in your Notice being rejected.**

**6. Witnesses**

If you plan to have witnesses testify at the hearing, provide names, addresses and telephone numbers along with a summary of the evidence each witness will give. Attach to this form.

**7. Additional information**

Will you be providing additional written submissions, information or evidence not included in your claim file?

Yes  No

**Information, submissions or evidence must be provided to the Tribunal and other parties 7 days before the hearing.**

(Evidence or information not provided 7 days in advance will not be accepted into the hearing.)

**8. Other WCB Claims**

I have previous WCB claims  Yes  No

If "yes" list which Board and claim number(s) \_\_\_\_\_

(Attach a separate sheet if needed) \_\_\_\_\_

Note: Employers should only list claims involving the same worker.

**9. Certification and Authorization**

**For workers:** I authorize Yukon Workers' Compensation Health and Safety Board to release any and all of my claim files, relevant to this appeal, to the Workers' Compensation Appeal Tribunal. All information gathered will be for the purpose of this appeal only.

**Employers:** For disclosure of worker's claim files, contact Yukon Workers' Compensation Health and Safety Board.

**I confirm the information on this form is correct and complete.**

\_\_\_\_\_  
**Signature of Appellant**

\_\_\_\_\_  
**Date** (yyyy-mm-dd)

Check here if more pages are attached.