



REQUEST FOR REVIEW BY HEARING OFFICER

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Telephone:** (867) 667-5645, **Toll free:** 1-800-661-0443, **Fax:** (867) 393-6279, **Website:** www.wcb.yk.ca

A review by the Hearing Officer is the first level of the claims appeal process. You are requesting this review under section 53 of the *Workers' Compensation Act* S.Y. 2008 (the "Act"). The Hearing Officer shall review the decision you disagree with and confirm, vary or reverse that decision. **Notice of the appeal must be filed within 24 months of the date of the decision by the Yukon Workers' Compensation Health & Safety Board (YWCHSB), in accordance with section 52 of the Act.**

<input type="checkbox"/> Worker	<input type="checkbox"/> Employer	Name	
Address			
City/Town			Postal Code
Telephone (home)		Telephone (work)	
Company		Claim Number	
Name of your worker or employer when the disability occurred			
You disagree with the decision dated (y/m/d)			

A - REASON FOR REVIEW

Please indicate why the decision is incorrect and how it should be changed.

B - METHOD OF REVIEW

Would you prefer?

A documentary review based on the information on file (*you do not have to attend*); or An oral hearing with the Hearing Officer

Do you have new medical or other evidence that you wish to submit? Yes No

Please list any witnesses who will testify including yourself: _____

Please briefly describe the testimony you or your witness will give at the hearing: _____

Will you be providing additional written information? Yes No

If Yes, please attach it to this form or provide it to the administration and other parties at least fourteen (14) days before the hearing. Otherwise, the hearing may be postponed or adjourned.

C - REPRESENTATION

Who will represent you in this proceeding? _____

If someone other than yourself is presenting your case please complete and attach form "Authorization for Representation"

D - ACCESS TO FILE

Workers (or the dependent of a deceased worker) and employers involved in a review, or their representative, are entitled to one free copy of the claim file upon request. Additional copies are available for a fee.

To obtain a copy of the file, you must submit a "Request for Disclosure" form to the YWCHSB. These forms may be obtained at the YWCHSB or by calling 667-5645.

Signature

Date

For further information about reviews or appeals, please contact the Appeals Assistant: YWCHSB: (867) 667-5645 or 1-800-661-0443 toll free.

Note: This information is being collected under the authority of the *Workers' Compensation Act* S.Y. 2008 or *Occupational Health and Safety Act* R.S.Y. 2002 solely for the purpose of your review or appeal. For further information about the collection of this information, please contact the Vice-President of Operations/CFO, YWCHSB: (867) 667-5645 or 1-800-661-0443 toll free.