Yukon Workers' Compensation Health and Safety Board

AUTHORIZATION OF A REPRESENTATIVE

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Phone:** 867-667-5645, **Toll free:** 1-800-661-0443, **Fax:** 867-667-8740, **Web:** www.wcb.yk.ca

Complete this form if you wish to appoint a representative and allow Yukon Workers' Compensation Health and Safety Board (YWCHSB) to disclose personal and confidential information about you or your business to your representative.

SCOPE OF REPRESENTATION

My representative is authorized to represent me with respect to the following YWCHSB matters (check all that apply):

Appeal or review matters:
- ☐ Claims
- ☐ Assessment
- ☐ Occupational health and safety

Other matters:
- ☐ Occupational health and safety
- ☐ Claims
- ☐ Assessment

☐ Other specific matter (explain):
_____
_____

ABOUT YOU

I am
- ☐ a worker – YWCHSB claim number:_____
- ☐ a deceased worker's dependent/spouse
- ☐ an employer – Employer customer number:_____
  Title and business name: _____
- ☐ other (explain): _____

Last name	First name		Middle initial
Mailing address	City	Province	Postal code
Daytime phone (include area code)	Other phone (include area code)	Fax (include area code)	

ABOUT YOUR REPRESENTATIVE (you may appoint an individual or an organization to represent you)

I authorize
- ☐ an individual – Name of person:_____
- ☐ an organization – Name of organization:_____
  Contact person: _____

Representative's mailing address	City	Province	Postal code
Daytime phone (include area code)	Other phone (include area code)	Fax (include area code)	

- I consent to YWCHSB disclosing to my representative the contents of any YWCHSB file(s) or related information for which I am eligible to receive disclosure. I authorize my representative to act on my behalf before YWCHSB.
- This authorization form will replace any previous authorization(s) I have submitted to YWCHSB for the same scope of representation identified in the scope section of this form.
- If I wish to cancel this authorization I must provide a written cancellation to YWCHSB.
- **For individuals:** This authorization shall remain in effect for two years from the date of signing, or until it is cancelled in writing, or until my death, whichever is earliest.
- **For employers:** This authorization shall remain in effect for two years from the date of signing, or until it is cancelled in writing, or the business is no longer active with YWCHSB, whichever is earliest.

_____ YYYY/MM/DD _____

Signature (you – **not** your representative) Date

This information is being collected for the purposes of administering and enforcing the *Workers' Compensation Act* and the *Occupational Health and Safety Act* and is collected under the authority of those Acts and the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, please contact the privacy officer at YWCHSB at the above listed address or at (867) 667-5645 or 1-800-661-0443.

YG(6624E)F1 01/2019

Print Clear