Workers' Safety and Compensation Board Yukon

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 Workers' Safety Compensation Board 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 matters (check all that apply):

Appeal or review matters:
- ☐ Claims
- ☐ Assessments
- ☐ Workplace health and safety

Other matters:
- ☐ Workplace health and safety
- ☐ Claims
- ☐ Assessments

☐ Other specific matter (explain): _____

ABOUT YOU

I am
- ☐ a worker – 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

Primary phone (include area code)	Alternative phone (include area code)	Email address (optional)

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

Primary phone (include area code)	Alternative phone (include area code)	Email address (optional)

- I consent to the board disclosing to my representative the contents of any board file(s) or related information which I am eligible to receive disclosure. I authorize my representative to act on my behalf.
- This authorization form will replace any previous authorization(s) I have submitted 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.
- **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shall remain in effect for two years from the date of signing, or until it is cancelled in writing, or the business is no longer active with the board, whichever is earliest.

_____ DD / MM / YYYY

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

This information is being collected for the purposes of administering and enforcing the *Workers' Safety and Compensation Act* in compliance with 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 the above listed address or at (867) 667-5645 or 1-800-661-0443.

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